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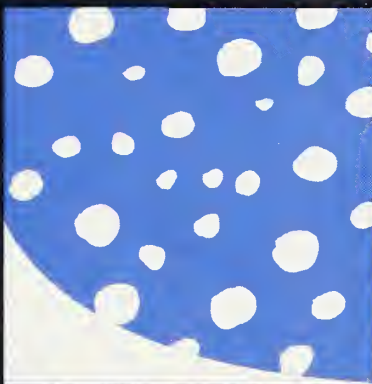
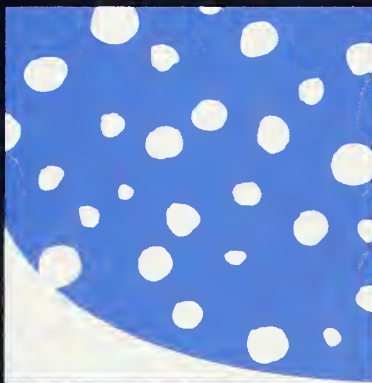
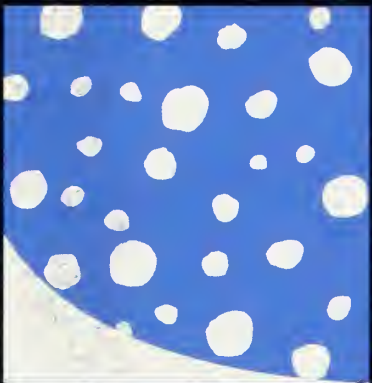
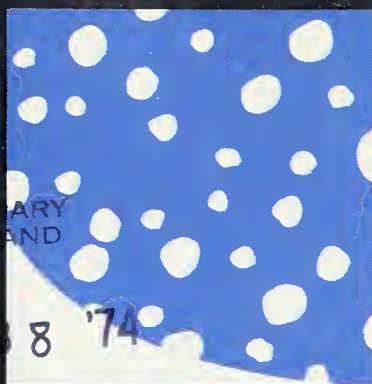


# JOURNAL

OKLAHOMA STATE MEDICAL

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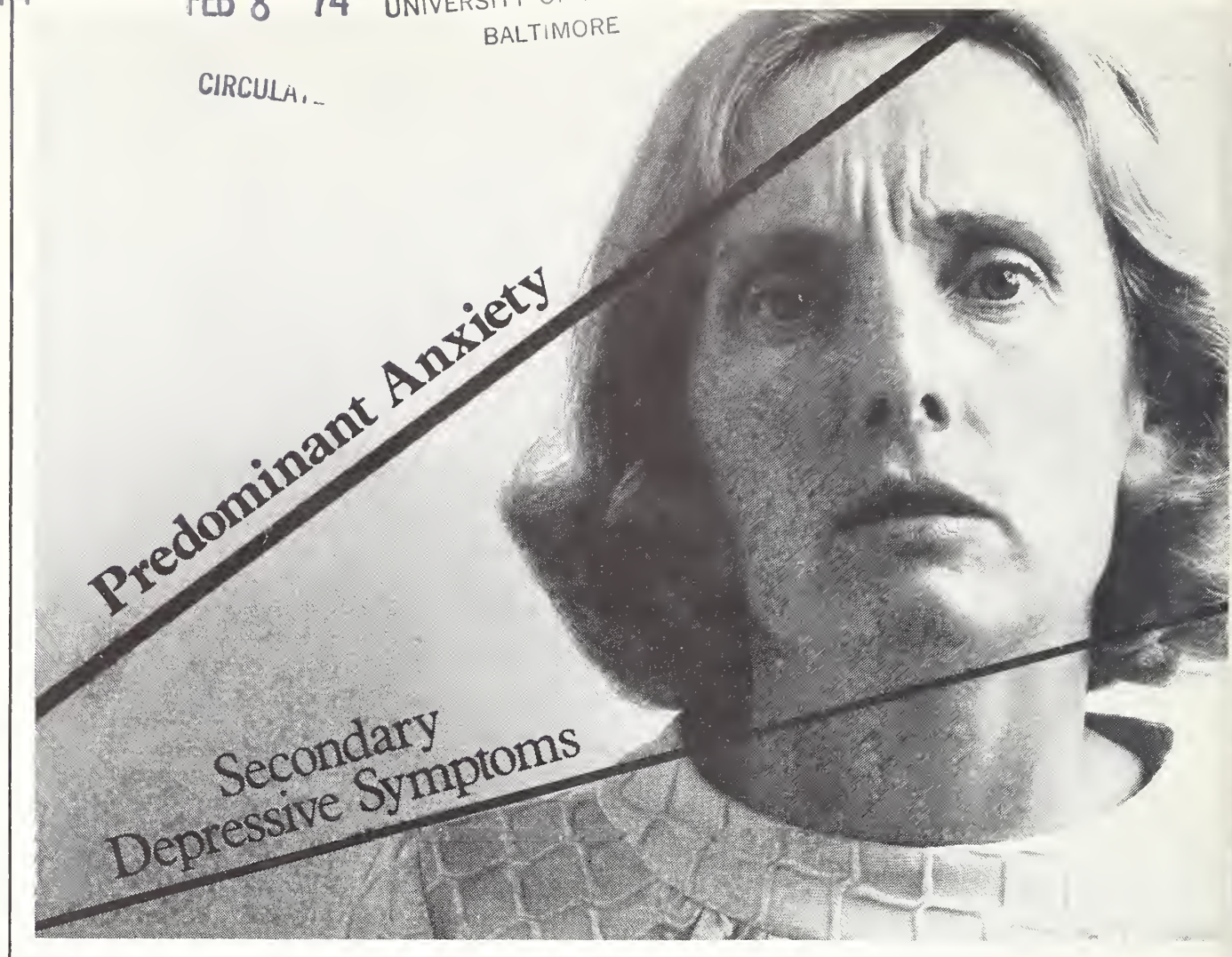
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REC'D

CIRCULAR

Predominant Anxiety

Secondary  
Depressive Symptoms



# This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive dis-

orders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant

medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

X76-60



## A Resolution For The New Year

Personally, I've never spent much time frettin' about medical ethics. My concept of ethical practice and conduct is pretty simple: Whatever act or statement is wholly honest, completely moral, thoroughly presented, unalterably confidential and totally devoid of venality is ethical. Whatever act or statement is dishonest or only partially honest, immoral, venal, misrepresented or undisclosed to the patient or revealed to others without the patient's consent is unethical. When I find it necessary to test the ethical quality of any act or statement, I apply two simple questions: Does it serve the best interests of the patient? And, would I understand and agree that it did if I were the patient?

I appreciate the fact that everyone, physician or not, has his own concept of medical ethics, but I doubt that many would substantially disagree with the principles I have enumerated as my own. So it follows, I guess, that most of us, physicians in particular, agree with me that the medical profession's participation in the activities initiated by Public Law 92-603 is unethical. And that the acts of physicians while serving with Professional Standards Review Organizations, and utilization review committees and prehospitalization evaluation groups are all unethical. If, for no other reason, all such acts are unethical because they are partially or wholly venal — open to corrupt influence, mercenary, capable of being bought. As Dr. Charles C. Edwards, Assistant Secretary for Health, has reminded us in his recent memorandum (as neat a job of sugar-coating a cyanide pill as I've ever seen and could be sub-titled 'Requiem for Private Practice'), "... The Federal Government spends \$17 billion a year on the Medicare and Medicaid programs and has a responsibility to see that the medical care paid for with public funds is necessary ... ." And there's more. "... If a physician's peers in the PSRO disapprove a proposed procedure or service or an extension of a length of stay, the immediate effect would be that the government would not pay for those services ... ." If this isn't mercenary, it isn't anything.

"... HEW will provide funding to the PSRO

to cover all necessary expenses involved in carrying out its functions, including the reimbursement of physicians for time spent participating in review activities ... The National Council consists of 11 physicians ... who are appointed by the Secretary of HEW ... (and) ... also includes physicians nominated by consumer groups and other health care interests ... Once a plan has been approved, HEW will contract with the organization to serve as a PSRO on a conditional basis ... ." If this procedure isn't open to corrupt influence or capable of being bought, 'Watergate' is just the name of an apartment house.

I could never agree that it's wholly honest to pretend that "... The primary emphasis of the PSRO program is on assuring the quality of medical care ... ." Or that it's completely moral to refer to the patients' tax dollars as "public funds." Or that the provisions of Public Law 92-603 have ever been thoroughly presented to our patients. Or that any single detail of a patient's medical record will be held unalterably confidential.

So, our duty is obvious — and urgent — and imperative. We must take the initiative, assume our rightful authority and resolve that *it is unethical for any member of the Oklahoma State Medical Association to sell, contribute or otherwise render services to a PSRO as defined by Public Law 92-603 or any similar superseding legislative mandates.*

Surely, each of us realizes that only we can make PSROs work. In effect we, whom repeated public opinion surveys have shown to be the most respected and most trusted of Americans, will deliver into the hands of politicians — among the least trusted of Americans according to the same surveys — the entire destiny of health care in this nation. If this is really what you want to do—if you really believe this is what your patients want you to do, join a PSRO.

If you don't want any part of it, adopt a new resolution.

And have a Happy New Year. MRJ



I hope that all of you have had a very Merry Christmas and a Happy New Year.

Please be reminded that the PSRO law went into effect January 1st, 1974. There was a great deal of discussion and revolt at the AMA House of Delegates meeting in Anaheim and Oklahoma was credited with starting the revolt to achieve a stronger AMA policy toward PSRO. It now behooves us to wait and see what the leadership of the AMA will do in following the directive of the House of Delegates. Great discussion was held in the reference committee on PSRO and its prospective repeal. A very eloquent speech was made against PSRO by Congressman Phillip Crane of Illinois. Apparently his speech swayed many of the delegates to support repeal, not to mention the admonishments from the Oklahoma delegation and others. You were well represented by the speeches made by Doctor Joe Crosthwait, Chairman of the OSMA Board of Trustees, and by Doctor Scott Hendren,

Delegate to the AMA, as well as the other Delegates, Alternate Delegates and Officers of your association.

At the reference committee a very amusing statement was made by a Kentucky physician, in which he said PSRO is "a concubine in the harem of socialism." Please take note of this and also read the news article about the Oklahoma Foundation for Peer Review on page 22 of this *Journal*.

Because of the possible rationing of gasoline by the 1st of March, I will try to set up district meetings in all of the other districts that I have not yet visited. I want to discuss the PSRO issue and other matters with as many Oklahoma physicians as possible. We must all put our shoulders to the wheel and work diligently in the year 1974 . . . for the advancement and protection of our profession.

I shall expect your help.

Fraternally,

*C. Riley Strong M.D.*

C. Riley Strong, MD



# The Diagnosis and Treatment of Surgically Correctable Causes of Neonatal Respiratory Distress

Diagnosis

DAVID P. CAMPBELL, MD

*Surgically correctable lesions can be rapidly diagnosed and correctly treated if a simple series of diagnostic maneuvers are carried out in every infant with respiratory distress.*

Most neonates with respiratory distress do not have problems amenable to surgical therapy. A small percentage will, however, have surgically correctable lesions. The differentiation between neonates requiring surgical intervention and those requiring nonsurgical treatment must be made immediately, for most of the surgically correctable lesions are life threatening. The infant with a surgically correctable lesion can, in fact, be made worse by inappropriate medical treatment.

Immediate identification of surgically correctable lesions causing neonatal respiratory distress depends upon a high index of suspicion and the routine performance of a series of simple, rapid diagnostic maneuvers as outlined below.

A chest x-ray, which includes the upper abdomen and neck, is the most fruitful diagnostic procedure in an infant with respiratory distress. We advise our residents to call for the x-ray technician as soon as they are informed of an infant with respiratory distress. The technician hopefully will be at cribside by the time the physician has finished with a few preliminary diagnostic maneuvers. The infant with significant respiratory distress will have tachypnea (respiratory rate greater than 60 per minute), nasal flaring, retractions, and possibly cyanosis.

Upon confronting an infant with respiratory distress, one should rapidly perform a series of simple diagnostic maneuvers to rule out a surgically correctable lesion as the causative factor. (Fig 1)

FIGURE 1  
DIAGNOSTIC PROCEDURES TO DETECT  
A SURGICAL LESION

1. OBSERVATION AND EXTERNAL EXAM OF HEAD AND NECK
2. SUCTIONING AND DIGITAL EXAM OF OROPHARYNX
3. AUSCULTATION OF CHEST
4. PASSAGE OF RADIOPAQUE NASOGASTRIC TUBE
5. DIRECT LARYNGOSCOPY
6. CHEST X-RAY INCLUDING NECK AND UPPER ABDOMEN

First, observe the patient briefly to confirm the degree of distress, and also to discover such obvious causes as Pierre Robin Syndrome (micrognathia, macroglossia, cleft palate) and tumors of the neck (congenital goiter, teratoma, cystic hygroma, etc).

Suctioning and digital examination of the oropharynx should be the second maneuver performed and will reveal retained secretions and masses of the oropharynx (lingual thyroid, cystic hygroma).

Auscultation of the chest should follow oropharyngeal examination. Although difficult to evaluate in the newborn, auscultation will reveal the markedly decreased breath sounds and mediastinal shift present in a tension pneumothorax. We have never been able, with certainty, to hear bowel sounds in the chest, indicating a diaphragmatic hernia, but it is reportedly a reliable sign.

After auscultation of the chest, one should pass a radiopaque naso-gastric (NG) tube through a nostril and aspirate the stomach. The passage of this tube will rule out bilateral choanal atresia and tracheoesophageal fistula as causes of the respiratory distress. We believe that the NG tube should be left in place until after a chest x-ray is obtained and it can be ascertained that the tube has actually passed into the stomach. We have been misled several times by naso-gastric tubes which were thought to have passed into the stomach, but were actually curled up in the proximal blind pouch of an esophageal atresia.

As a final step before x-ray of the chest, we suggest a quick examination of the laryngeal area with a laryngoscope. This will disclose such rare entities as subglottic stenosis, webs, bilateral vocal cord paralysis, laryngoceles, and other obstructive lesions, if present.

As noted above, radiographic examination of the chest will prove to be the most fruitful diagnostic procedure. The PA and lateral views should include the neck and upper abdomen in the search, as the condition responsible for the distress may exist above the thoracic inlet or below the diaphragm.

#### Treatment

Since many of the surgically correctable causes of neonatal respiratory distress actually can be worsened by inappropriate medical

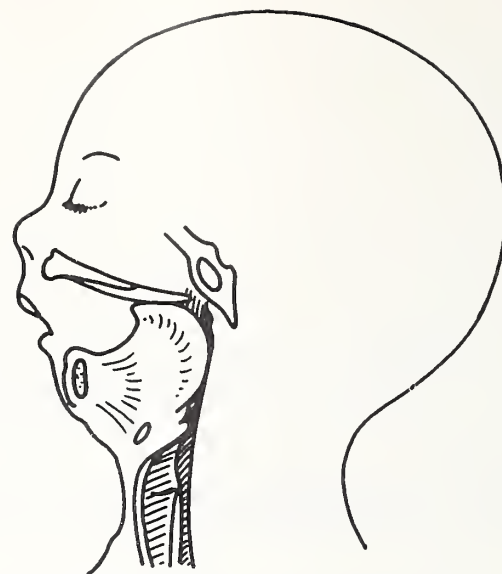


Figure 2. Pierre Robin Syndrome.

treatment, some suggestions on the immediate treatment of these infants are in order. We will discuss those conditions most frequently encountered at the University of Oklahoma Medical Center. Many of these infants require transportation from the primary care facility to a definitive care center. Suggestions regarding preferred modes of transportation will therefore be made.

(1) *Pierre Robin Syndrome*: The hypoplastic mandible, large tongue, and cleft palate found in these infants can cause severe upper respiratory obstruction. The diagnosis is obvious on inspection. (Fig 2) The obstruction results from the tongue falling back into the oropharynx and is relieved when the infant is placed on its abdomen with the feet elevated to 45 degrees. This allows the tongue to fall forward out of the oropharynx. These infants require constant intensive nursing care with frequent aspirations of the oro- and nasopharynx. If an adequate airway cannot be maintained with the maneuvers outlined, we recommend

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*Since his graduation from the University of Oklahoma College of Medicine and Dentistry, David P. Campbell, MD, has been certified by the American Board of Surgery. He is now Assistant Professor of Surgery and Pediatrics at the school of his graduation. Among his medical affiliations are the Association for Academic Surgery, the Central Oklahoma Pediatric Society, the Southern Society for Pediatric Research and the Southwest Oncology Group.*



proceeding to tracheostomy rather than any of the numerous surgical procedures designed to hold the tongue forward. We have found all unsatisfactory. Infants with Treacher-Collins Syndrome (mandibular facial dysostosis) present with similar problems and should be treated accordingly. The mandible in both of these syndromes will gradually enlarge to the point where glossoptosis and subsequent respiratory obstruction are no longer a problem.

When infants with Pierre Robin Syndrome or Treacher-Collins Syndrome are transferred, they should be moved in a heated, humidified bassinet in the prone Trendelenburg position. Adequate suctioning apparatus must be available in the transport vehicle.

(2) *Congenital Choanal Atresia*: The newborn infant is an obligate nose breather. Bilateral nasal obstruction can therefore lead to rapid asphyxiation. Choanal atresia can be immediately ruled out as a cause of neonatal respiratory distress by the passage of a nasogastric tube through a nostril. Infants with unilateral lesions have little problem breathing. In almost all cases of bilateral choanal atresia, the obstruction is bony and requires surgical correction. A definitive surgical attack on the atresia need not be performed until approximately one year of age. The immediate problem can be handled with an oral airway and astute nursing care. The problem will usually correct itself within two to three weeks after birth when a pattern of mouth breathing is established.

Infants with choanal atresia usually can be cared for at a primary care facility. If transportation for referral is necessary, it should be done with an oral airway in place in the infant and suctioning equipment available.

(3) *Laryngeal Lesions*: Laryngeal obstruction can be caused by lesions such as webs, subglottic stenosis, and tumor masses. Bilateral vocal cord paralysis, most often secondary to central nervous system injury, is another etiologic factor. Laryngeal lesions can be seen on x-rays of the neck (lateral views) but are best diagnosed by direct laryngoscopy which should be part of the routine examination of a newborn with respiratory distress. Emergency tracheostomy is often required in these cases with lesions of the laryngeal area if the degree of obstruction is severe enough to cause respiratory distress. If at all possible, tracheostomy in an infant should be performed in the operating room after an endotracheal tube has been inserted.

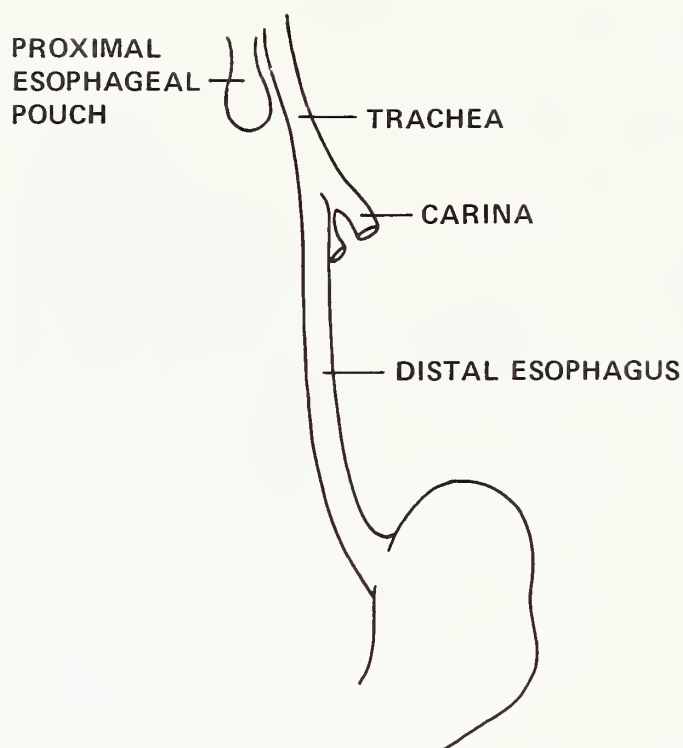


Figure 3. Esophageal atresia with tracheoesophageal fistula (most common type).

We routinely perform a tube gastrostomy under local anesthesia as an emergency procedure in these infants. Once a gastrostomy is provided to prevent reflux of gastric contents into the pulmonary tree, one can perform repair as a semi-elective procedure. A decision as to whether primary repair or a staged procedure should be carried out depends upon the size, maturity, and pulmonary status of the infant. We usually repair the tracheo-esophageal fistula via a right retropleural approach.

(4) *Tracheo-esophageal Fistula*: This lesion does not usually cause immediate respiratory distress. The first symptom usually noted is the constant bubbling of secretions from the infant's mouth and nose. Also, there is prompt regurgitation of the first feeding. The respiratory distress which eventually occurs is due to aspiration of saliva, which overflows from the proximal blind pouch, and regurgitation of gastric contents through the fistula into the tracheobronchial tree. The most common anatomical arrangement in tracheo-esophageal fistula (approximately 95%) is a blind proximal esophageal pouch with the distal esophagus connected to the tracheobronchial tree at the level of the carina. (Fig 3)

Tracheo-esophageal fistula can be diagnosed when one attempts passage of a radiopaque nasogastric tube into the stomach. Many of these cases would be diagnosed earlier if passage of an NG tube and aspiration of the infant's



stomach would once again become standard delivery room practice. The naso-gastric tube should be left in place until chest x-rays are obtained (Fig 4) for it may seem to pass into the stomach, but actually be curled up in the proximal pouch. An x-ray of the chest will clearly show this. As a further confirmatory study, a small amount of a water soluble contrast material can be injected down the tube into the proximal pouch. (Fig 5) We perform this study in the x-ray suite under fluoroscopic control. Suction apparatus should be available, and the contrast medium aspirated from the proximal pouch as soon as appropriate films are obtained. Only one to two cubic centimeters of contrast agent are necessary to outline the upper pouch.

The immediate care and transportation of infants with tracheo-esophageal fistula requires several maneuvers designed to prevent aspiration of saliva and regurgitation of gastric contents. The infant should be placed in a heated, humidified isolette with a Replogle-type sump catheter through a nostril into the proximal pouch. This sump should be attached to a constant suction device. The infant's head should be elevated approximately 45 degrees to minimize reflux of gastric contents into the pulmonary tree. The oropharynx should be suctioned at frequent intervals. Infants to be transported should be placed in a heated isolette, with the head elevated and suction ap-



Figure 4. Radiopaque NG tube in proximal pouch of esophageal atresia with TEF.

paratus available for both the upper pouch tube and the oropharynx.

(5) *Diaphragmatic Hernia*: The signs and symptoms of congenital diaphragmatic hernia usually appear shortly after birth. In fact, the earlier the respiratory distress becomes evident, the more serious is the problem and the more urgent the need for surgical correction.

As one performs the steps outlined above (Fig 1) to rule out a surgically correctable cause of respiratory distress, he will note a decrease of breath sounds and perhaps bowel sounds on the affected side in the infant with diaphragmatic hernia. Chest x-ray findings will be diagnostic and will reveal multiple loops of bowel in a hemithorax. (Fig 6)

Diaphragmatic hernia is usually secondary to a posterior-lateral defect (Foramen of Bochdalek) which allows herniation of the abdominal contents into the pleural space. The resultant respiratory distress is due to compression of the lung on the ipsilateral side which may progress to shift of the mediastinum and compression of the contralateral lung. Diaphragmatic hernia is more common on the left side, probably because of the protective effect afforded by the liver on the right side.

Infants with diaphragmatic hernias generally suffer from severe respiratory distress and require immediate surgery. All efforts prior to surgery should be aimed at prevention of dilatation of the bowel herniated into the pleural space. A sump-type NG tube should be inserted immediately and attached to suction. The infant should be placed in a heated isolette with the delivery of a high concentration of oxygen, which is rapidly reabsorbed from the bowel lumen. If ventilatory assistance is required, an endotracheal tube should also be inserted. Bag breathing these infants is absolutely contraindicated. Bag breathing forces massive amounts of air into the herniated loops of bowel, further compromising respiratory reserve. These infants should be transported with functioning naso-gastric and endotracheal tubes in place. They should be accompanied by personnel capable of replacing the endotracheal tube.

We take these infants to the operating room immediately, and if possible correct their respiratory acidosis and secondary metabolic acidosis before proceeding with operation.





Figure 5. Contrast study of upper pouch in esophageal atresia with TEF.

We prefer to approach diaphragmatic hernias via the abdominal route for the following reasons: (1) There is a high incidence of concomitant intra-abdominal anomalies, especially those related to intestinal rotation. (2) We believe it technically easier to extract the trapped intestine from below. (3) If return of the intestine to the abdominal cavity causes respiratory distress because of increased intra-abdominal pressure, one can easily create a temporary ventral hernia.

(6) *Congenital Lobar Emphysema*: Respiratory distress in lobar emphysema is due to progressive overinflation of an upper or middle lobe with secondary compression of the remaining functional lung tissue. The symptoms usually manifest themselves in the first several weeks of life. The primary causal factor is thought to be bronchial dysplasia with a ball/valve effect causing air trapping in the affected lobe.

If one follows the diagnostic plan outlined above (Fig 1) he will note hyperresonance and diminished breath sounds on the infant's affected side. Chest x-ray will reveal a translucent area with compression of the remaining ipsilateral and contralateral lung. (Fig 7) The mediastinum will be shifted away from the translucent area.

It is sometimes difficult to distinguish between congenital lobar emphysema and pneumothorax. If one examines the chest film carefully he will note bronchovascular mark-

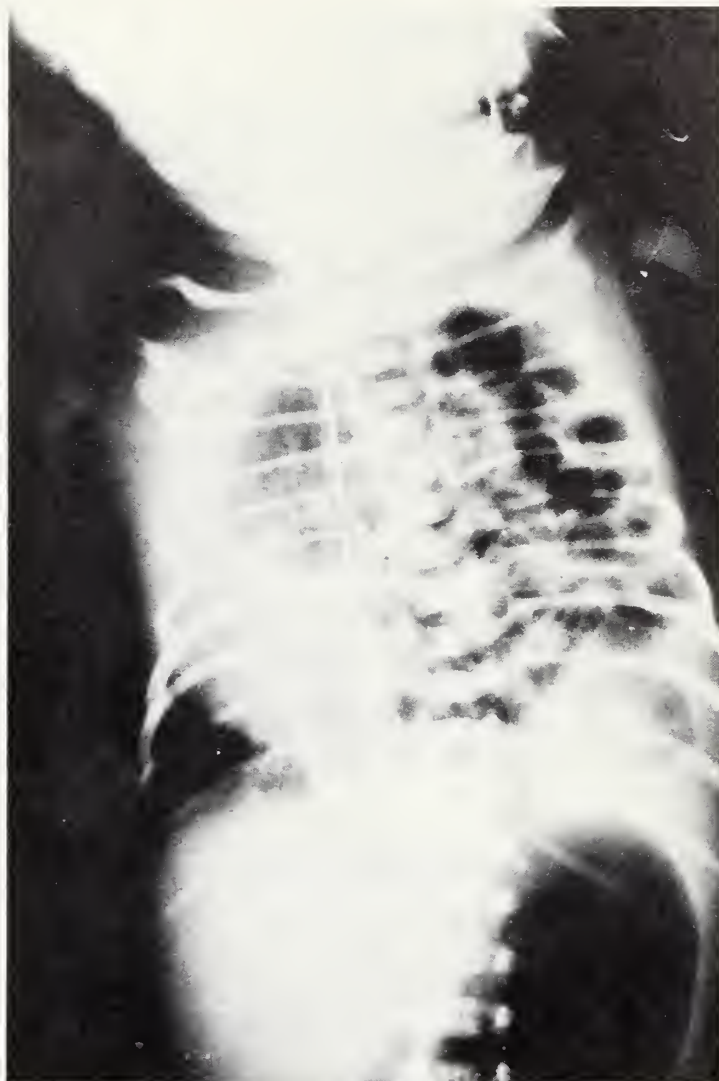


Figure 6. Left diaphragmatic hernia.

ings out to the very edge of the translucent area in lobar emphysema.

Infants with congenital lobar emphysema require immediate thoracotomy and lobectomy. We have seen infants in such distress that thoracotomy without anesthesia was necessary to release the pressure of the over-expanded lobe. Anesthesia was then induced, and lobectomy performed.

We believe that bronchoscopy and bronchography are contraindicated in these infants. They are seldom of help diagnostically and can lead to the rapid demise of an infant with an already severely compromised pulmonary reserve.

The immediate treatment of these infants prior to surgery entails providing a heated, humidified isolette with oxygen. If referral is necessary they should be transported in such an environment. It should be mentioned that insertion of a chest tube into an emphysematous lobe provides no relief of the problem.



(7) *Pneumothorax*: Pneumothorax is probably the most common cause of respiratory distress seen in the newborn. It is often accompanied by pneumomediastinum. The air leakage into the pleural cavity is usually due to over-distension and rupture of the infant's fragile alveoli. The most common cause is overzealous resuscitation of an apneic or hypoxic newborn. Spontaneous alveolar rupture may, however, occur as a result of the stresses accompanying the first few breaths of life. A persistent leak into the pleural cavity will cause tension pneumothorax with shift of the mediastinum, compression of the contralateral lung, and decrease of venous blood return to the heart. Pneumothorax should always be suspected in the infant with mild to moderate respiratory distress whose condition suddenly worsens.

Utilizing our suggested diagnostic work up, (Fig 1) one will note decreased breath sounds and hyperresonance to percussion on the affected side. A shift of the cardiac impulse will also be noted if tension pneumothorax is present. Chest x-ray findings are diagnostic.

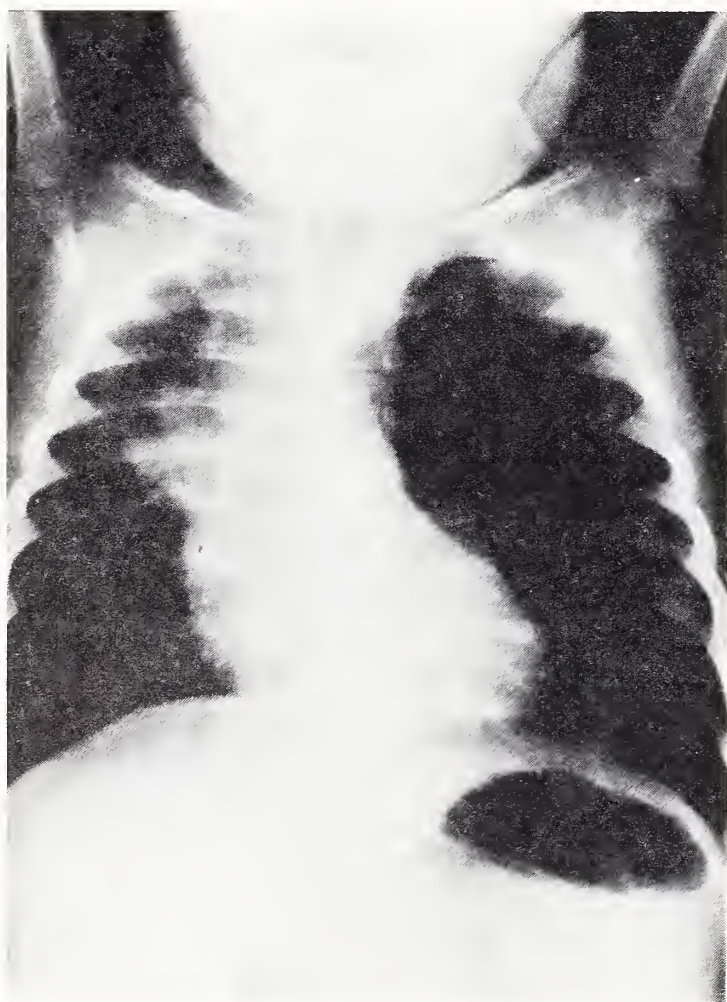


Figure 7. Lobar emphysema—left upper lobe.

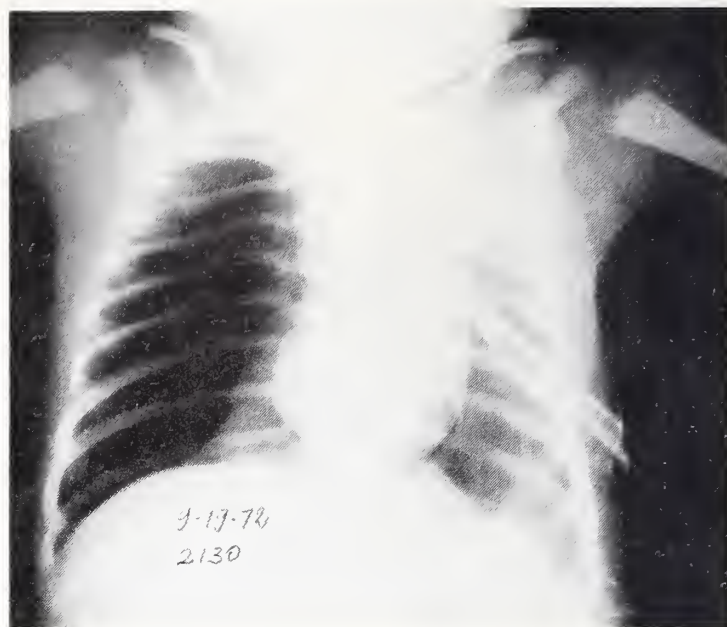


Figure 8. Right pneumothorax in patient being treated for a previous left pneumothorax.

Pneumothorax is one of the surgically correctable causes of neonatal respiratory distress that can always be treated in the primary care facility. Degrees of pneumothorax of 15% or less usually can be treated expectantly. Intrapleural and mediastinal air is rapidly resorbed by these infants — especially if they breathe air with increased concentrations of oxygen. Any underlying pulmonary disease may, however, make even a mild degree of pneumothorax intolerable.

Respiratory distress may make needle aspiration of the affected pleural space mandatory. Needle aspiration, if performed correctly, will cause little harm even if the wrong diagnosis has been made. We prefer to use an eighteen gauge needle with a twenty to fifty cubic centimeter syringe and enter the pleural space through the fourth intercostal space in the anterior axillary line. The needle is kept on the superior border of the adjacent rib to reduce the chance of injury to the nerve and artery which are found on the inferior aspect of the rib. The spatial arrangements of the infant's chest make injury to the subclavian artery and vein too probable to attempt aspiration in the second intercostal space in the midclavicular line as is often performed in adults.

We believe that a chest tube should be inserted in all cases of significant pneumothorax (15 to 20% or greater). Again we place the chest tube through the fourth intercostal space in the midclavicular line. Trochars, often used for the placement of chest tubes, are dangerous to use on infants. Using a hermostat we simply force the soft rubber tube through the chest



wall after making a preliminary skin incision. We connect the chest tube to an underwater seal, for suction is rarely necessary. The tube can usually be removed within forty-eight to seventy-two hours. One should always be aware of the possibility of pneumothorax on the contralateral side when any infant treated for pneumothorax suddenly develops renewed respiratory distress (Fig. 8).

### Summary

Although most causes of respiratory distress in the newborn are due to factors which are best treated medically, there are a few problems which require immediate surgical evaluation and treatment. These surgically correctable lesions can be rapidly diagnosed if a simple series of diagnostic maneuvers and procedures are rapidly carried out with every infant in respiratory distress.

### SUGGESTED READING:

1. Haller, J.A. and Talbert, J.L. Surgical emergencies in the newborn. Philadelphia, Lea & Febiger, 1972.
2. Lynn, H.B. The role of surgery in respiratory emergencies. *Ped. Clin. North Amer.* **20**: 323, 1973.
3. Pickett, L.K. The role of surgery in neonatal respiratory distress. *Hospital Practice Feb.*: 85, 1969.
4. Schapiro, R.L. and Evans, E.T. Surgical disorders causing neonatal respiratory distress. *Am. J. Roentgenol., Rad. Therapy & Nuclear Med.* **114**: 305, 1972. □

P.O. Box 26901, Oklahoma City, Oklahoma 73190.

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## *38th Internal Medical Assembly Slated to Meet In San Antonio, Texas*

Historic San Antonio will again play host for the International Medical Assembly of Southwest Texas. The 38th Annual Meeting will be held in the El Tropicano Motor Hotel, February 28th and March 1st, 1974.

The site of the meeting is within easy walking distance of the famed Alamo and the city's almost equally famous River Walk, a beautiful display of gardens, sidewalk cafes, Mexican shops and arched stone bridges winding through the downtown area along the San Antonio River.

San Antonio, one of America's four unique cities, and once considered to have a climate so healthful and harmless that the people could get along very well without a doctor, will welcome about 700 physicians, and their families, from throughout the United States and Mexico.

The distinguished speakers for the 38th International Medical Assembly are:

Adolescent Medicine — Michael I. Cohen,

MD, Bronx, New York

Family Practice — James G. Price, MD,  
Brush, Colorado

Cardiology — Frank W. Koetz, MD,  
Memphis, Tennessee

Cardiovascular Surgery — Edward B.  
Diethrich, MD, Phoenix, Arizona

Internal Medicine — Leonard L. Madison,  
MD, Dallas, Texas

Neurosurgery — Robert G. Ojemann, MD,  
Boston, Massachusetts

Pediatric Allergy — Elliot F. Ellis, MD,  
Denver, Colorado

Plastic Surgery — Charles E. Horton, MD,  
Norfolk, Virginia

Surgery — Edgar C. White, MD, Houston,  
Texas

Those interested in receiving further information or registering, may write Mr. S. E. Cockrell, Jr., Executive Director, 202 West French Place, San Antonio, Texas 78212. □

# Centennial Year of Nursing Education An Oklahoma Perspective

MARTHA L. STOCKWELL, MN  
JESSCELIA NUNLEY, BSN

*During the twenties there were thirty-six hospital-based schools for nurses and now there are two. Baccalaureate and Associate Degree programs are in the ascendancy. Why?*

## Introduction

During the year of 1973, Oklahoma nurses participated in the National Centennial Celebration of formal nursing education in the United States. Linda Richards was the first student to finish a course for nurses at the New England Hospital for Women and Children, Roxbury, Massachusetts, in 1873.

In these one hundred years, an industrial revolution and knowledge explosion have influenced the practice of medicine and nursing. The Sooners started later but can challenge the front-line of nursing education with their progressive schools and innovative curricula.

The development of nursing education in Oklahoma was associated with the development of the state government. In 1908, a year after statehood was granted, a bill to regulate nursing practice was introduced in the legislature.

Approximately seven "training" schools were in operation and approved. The total number of schools expanded to thirty-six in the nineteen twenties, and reduced to eleven in the nineteen fifties.<sup>1</sup>

Social, political, and scientific trends have placed their mark on the schools of today. As we look back through the pages of history and talk with nurse educators, certain eras are seen to dominate the evolution of nursing and nursing education in Oklahoma.

## The Early Days

In 1908, nursing education was more apprentice-like, for students worked long hours on hospital wards and even in kitchens. A typical day might be twelve hours of floor duty, and a class or two. Classes were generally taught by physicians, and a few hours comprised a course in each of the medical specialty areas. There were no Registered Nurses, but nurses completing a program were graduate nurses. The attitudes of a Victorian society were evidenced in the anatomy book, which did not include the male reproductive system.

During this time, private duty nurse Golda Slief recalled staying in homes on twenty-four hour duty, cooking, cleaning, caring for children as well as the patient. Sometimes nights were spent sleeping outdoors in a wagon bed.<sup>2</sup>



Nursing schools were a part of the hospital systems and were supervised by hospital administrators. Because of the proliferation of programs and the particular goals of each institution, the quality of nursing education varied markedly and reflected the goals of the particular institution. On September 1, 1908, nurses met in Oklahoma City to draw up a nursing practice act, which was adopted January 27, 1909. Physicians were influential in the passage of the bill, and also in upholding the specification of a high school education as a provision for registration.

### Organizing Standards: 1913-1933

Leaders for nursing education recognized the necessity of setting standards. Therefore, in 1914, the National League for Nursing Education (NLNE) spearheaded preparation of a Curriculum Guide, published in 1917. Quality education in Oklahoma was boosted by Jessie Bidle, who served as Secretary-Educational Director of the State Board from 1929 to 1951. She traveled throughout the state urging nursing educators to improve their schools, using the standards in the NLNE Guide Book.

There was a steady increase in the population, over 0.7 million from the 1910 census of 1.6 million. The number of approved nursing schools was about 26 in 1918 and 36 in 1926. Courses of study were more organized, but continued to be fragmented. The curriculum of one school in 1925-28, listed twenty-six separate courses totaling 531 clock hours. Many courses, such as Hygiene, English, and Bandaging were ten hours each. Pediatrics and Contagious Diseases were twenty hours. The most hours, 90, were devoted to Nursing Principles and Methods. Anatomy and Physiology was second with 52 hours. The Nursing Director was the administrator of the school and taught Ethics. One or two of the nursing faculty taught a few courses, but the majority were taught by physicians. The nursing faculty had additional responsibilities in supervision of student health, relieving hospital personnel, switchboard operators, and setting up the morgue.<sup>3</sup>

Nursing students were expected to work sixty or more hours a week on the wards, and attend classes. They were paid \$8.00 to \$12.00 a month, plus room and board. It was usual for the students to graduate and stay on at the hospital, and after three years of work-study, their skills were highly developed. There was no need for

ancillary personnel as nurses did almost everything to keep the hospital wards running efficiently. The simplicity of equipment and the scope of medical activities did not demand the knowledges and skills of the present health care delivery team.

These also were the days when physicians and nurses worked in close alliance in patient care. Ada Hawkins, Professor Emeritus, University of Oklahoma, recalls being one of "Fowler's Girls," and accompanying Dr. William Fowler, obstetrician, for home deliveries during the middle twenties.

Regulations for nursing students were very strict. Students lived in dormitories and were permitted to leave only to visit their families. A student was expelled from the school if she married. There really wasn't any reason a student could not work a particular shift, because she was always available.

### Social Change: 1934-1945

The effects of the national economic depression, compounded by the Southwestern drought, brought despair and poverty to Oklahomans. Many people left the state during the dust bowl days. With the reduction of funds for hospital operation, the training schools systematically continued to supply the manpower for the care of patients, as well as for much of the ancillary activities. Some nurse aides were hired to perform a few simple chores around the ward, freeing the nurses for more bedside nursing activities.

Oklahomans responded to the national issue of upgrading the quality of nursing education. A token of new attitudes was demonstrated by changing the titles of training schools to schools of nursing. On the national scene, work began on a new *Curriculum Guide for Schools of Nursing*<sup>4</sup>, published in 1937. (Interestingly, Lucy Germain, now acting Assistant Administrator for Nursing, University Hospital, attended one of the first national workshops on this revised curriculum.)

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Following the Curriculum Guide, nursing schools presented a range of 1,200 to 1,300 clock hours of class work in three years. Physicians continued to be the chief lecturers for nursing students, with one or two nursing faculty members coordinating the classes, instructing nursing arts and supervising nursing practice. Juanita Millsap, Oklahoma Baptist University Assistant Professor in Nursing, explained how the hospital was staffed with nursing students.<sup>5</sup> During the first six months, the student spent most of her time in classes, with beginning nursing skills taught on the wards. Then the students were ready to work on the medical-surgical wards, and another class was admitted. With classes admitted every six months, there were always students available on the wards as classes were staggered over the twelve-hour shift. Students rotated through each service, obstetrics, pediatrics, operating room, so all units were staffed. By the third year, students were ready to function in a head nurse capacity, and would be responsible for new students on the nursing division.

Blacks who aspired to a nursing career, had to leave the state to seek admission to schools of nursing. Upon graduation, their employment was restricted primarily to institutions for blacks.

Throughout the depression years and war years, the effects of the economy and manpower shortages were evidenced by the dwindling number of nursing schools, 25 in 1931, 16 in 1936, 12 in 1945. With other occupations opening up to women, an influx of nursing assistants and volunteers coming on the hospital scene, and new knowledge to assimilate, nursing education programs began to shift to academic settings.

#### New Directions: 1945-1965

When World War II ended, health care had assimilated a number of discoveries and innovations. The approaches of pooling resources and active research were to continue to bring rapid changes in the health care field. The spectrum of health care workers was ever widening, and hospital operating costs kept increasing.

At the same time, as schools of nursing introduced newer instructional systems, society was accepting a shorter work week. The "service" hours nursing students formerly contributed were greatly reduced. Nurse educators were

more vocal in expressing the philosophy that nursing students were assigned patient care in the hospital setting to *learn*, and not to staff the wards. In an effort to provide personnel for staffing on a limited budget, more ancillary help was hired. By 1950, it was apparent that controls should be placed on those persons practicing nursing under supervision, and a regulatory law was passed in the legislature for licensing practical nurses, effective April 13, 1953.

Oklahoma was slow in following the national trend toward baccalaureate education programs. The University of Oklahoma instituted the State's first program in 1951, but this was not accorded National League for Nursing accreditation until 1963. Oklahoma Baptist University began a program in 1952, and was accredited in 1962.

Recognizing the need for skilled nursing care and the necessity of baccalaureate and graduate education to provide nursing efficacy, Federal legislators took action. Bills were passed which provided the funds for traineeships, research project grants, and construction grants for schools.

Education for registered nurses was by diploma or baccalaureate degree programs. In 1960, there were nine diploma programs and two baccalaureate programs. Some colleges gave blanket credit to a diploma graduate and conferred some kind of degree in nursing. These programs were not NLN accredited, nor recognized when the person applied for admission to out-of-state graduate colleges.

By 1965, Oklahomans recognized a trend and an associate degree program of two years was begun at Cameron College.

In order to clarify the purposes for the variety of nursing education programs, the American Nurses Association (ANA) published a position paper December, 1965. The paper explained the different programs of study in nursing. In many groups, the statements provided a basis for argument. Diploma prepared nurses, who comprised eighty-five percent of the nurse manpower, were angry because of the term "technical." Hospital administrators felt the control of nursing education slipping away, and also the fringe benefits of service and employment after graduation. Physicians made comparisons between the highly skilled bedside nursing of the graduate from a diploma program and the less skilled baccalaureate graduate. After working with baccalaureate graduates, however, physicians tolerated their lack of skill, because skill



was quickly developed in the work situation. Physicians became aware of the knowledge and problem solving ability of the baccalaureate graduate.

It is interesting to note that the first baccalaureate programs in Oklahoma were championed by physicians, who saw the need for higher education as preparation for professional nursing. One leader was Doctor Ben H. Nicholson.

During this period another major step in Oklahoma was racial integration. Blacks and Indians were to become prominent in Oklahoma as leaders in nursing. Another minority group, men, had to counter social attitudes, and are now achieving their place in nursing.

#### A Dynamic Tomorrow: 1965-

Keeping up with the pace of the knowledge explosion and technological advancements, nursing educators made dramatic changes in curricula. Courses were developed with integrated content, reflecting a humanistic philosophy. Concepts are broad and inclusive. For instance, dependency relates to all specialty areas of practice, and in all settings.

A major triumph for the State was the founding of the University of Oklahoma College of Nursing Graduate Program. Planning began in January, 1972, and the first students were admitted in August, 1972. With this educational program, Oklahoma is assured of nursing leadership for the state. Nurses are prepared on the master's level for roles as "advanced nurse

practitioner, teacher - educator, supervisor-administrator, investigator and consultant."<sup>6</sup>

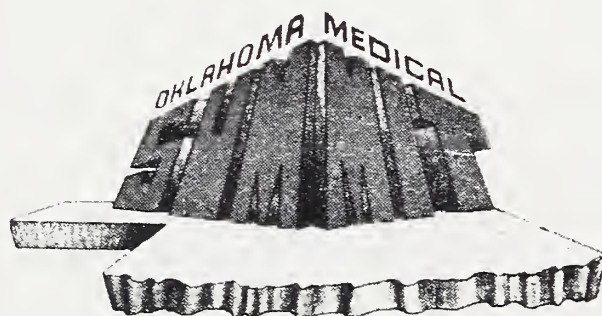
Reflecting the ANA position on education for nursing, many diploma schools phased out of existence. Associate degree programs became popular. Now, there are three diploma schools and nine associate degree programs in Oklahoma. Five colleges and universities confer baccalaureate degrees in nursing. In addition, there are twenty approved schools for practical nursing.

With spiraling costs, it is a temptation to fall into the 1920 trap of establishing schools of nursing to supply local sources of manpower. There is still a scarcity of qualified faculty and an uncertainty about state funding, both essential for quality education. Of one thing we can be sure; nursing education programs in Oklahoma have become recognized on the national scene, and there are exciting and productive years ahead. □

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REMEMBER THESE DATES

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**OKLAHOMA MEDICAL SUMMIT**





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**Contraindications:** In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

**Warnings:** Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

**Usage in pregnancy:** Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

**Precautions:** Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

**Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

**Dosage and administration:** Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

**Overdosage:** Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

**Dosage forms:** Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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# *The New Supplemental Security Income Program:*

A Prospectus for the Medical Community

J. FLOYD MOORMAN, MD

*A new program of supplemental security payments will become effective soon. It appears to meet a real need in a rational and much simpler way.*

On January 1, 1974, a nationwide program of direct federal payments to aged, blind or disabled persons with limited income and resources goes into effect. Known as "Supplemental Security Income" (SSI), the new program will have uniform eligibility requirements for such persons to replace the multiplicity of requirements existing under the present Federal-State public assistance programs.

The SSI program will be wholly financed from federal general tax revenues. Responsibility for administering the program has been given to the Social Security Administration (SSA) not only because of their experience in managing a monthly benefit payment program and the existing SSA advanced data processing system, but also because of the well-established nationwide network of SSA offices and program centers.

The title of the program—Supplemental Security Income—indicates that these benefits are expected in most cases to *supplement* income

from other sources, including social security benefits. Those persons receiving public assistance on the basis of age (65), blindness, or disability according to state plans in effect for October, 1972 and who received such aid for December, 1973 will, in general, be converted to the federal rolls beginning January, 1974. Further, blind and disabled recipients for SSI program purposes so long as they continue to meet the definition of blindness or disability under the state plan or the provisions for blindness or disability that apply to new claimants under the federally administered program after December, 1973. According to preliminary data, it is estimated that about 6.2 million people including approximately 1.6 million blind and disabled people will be eligible in January, 1974 on this basis.

The federal law will pay many people who are not now eligible under state programs because they have income or resources above specified levels, or because their states have requirements making relatives responsible for their care. Also, many people who actually meet the state requirements do not apply for public assistance payments in states which have lien laws. Since the federal law has neither lien law nor relative-responsibility provisions, more people are expected to apply.

The states may, at their own option, elect to supplement the federal SSI payment. Estimates are that about a million of the SSI



recipients will receive additional state aid beyond the federal payment.

The SSI program will generally use the same definitions of disability and blindness used in the social security disability insurance program for determining eligibility in new claims. To help simplify and speed the processing of disability decisions and to insure uniform treatment of all applicants, no matter where they live, the medical evaluation criteria developed for the Title II disability insurance program (social security) with the aid of practicing physicians, medical organizations and the Medical Advisory Committee to the Social Security Administration have been generally adopted for the SSI program. The evaluation criteria described in terms of symptoms, signs and laboratory findings, impairments that reflect the level of severity that would prevent most people from working for a year or longer. These criteria are constantly being refined to reflect advances in medicine and to take into account disability program experience.

If an applicant has an impairment or a combination of impairments that meets or equals the criteria, and he is not working, he would generally be considered disabled. Most allowances are based on medical considerations alone—that is, the claimant's impairment meets or equals the level of medical severity in the criteria. It is also possible for an impairment to be slight or minimal thereby resulting in a denial strictly on a medical basis. However, for workers who have impairments which fall short of the listed level of severity but which prevent them from doing their previous or customary work, consideration is given to their ability to do any other work in light of their remaining capacity and of their age, education, training and work experience. In these cases, the individual must not only have an impairment which prevents him from doing his usual work, or work he has done previously, but also must be unable to do other kinds of work for which he is reasonably suited. In the situation where an older worker with a marginal education and a long history of arduous unskilled physical labor has an impairment which prevents him from doing his usual work, he may be considered under a disability.

All persons whose applications for determinations of disability are adjudicated in a state disability determination unit are referred to the state vocational rehabilitation agency for consideration of rehabilitation services. The states

will be fully reimbursed by the federal government through the Rehabilitation Services Administration for the services they provide to qualified disabled and blind SSI recipients.

With the anticipated doubling of the state disability determination unit workloads, emphasis will be placed on expanding resources within the medical community so that we will be able to get medical reports needed for adjudication of claims as quickly as possible. Although generally the same guides apply under Title II and Title XVI there are some differences. For example:

1. *No Waiting Period* Under Title XVI (SSI), an individual who is determined to be blind or disabled will be eligible for payment for the first month in which he has filed an application and is disabled. There is no set waiting period which must be served after the onset of disability and during which payment cannot be made. (Under Title II, a five-month waiting period must be served after the onset of disability.)

2. *Presumptive Disability* The law provides that an applicant for disability benefits who is found to be "presumptively disabled" may be paid, under certain conditions, for as many as three months while a formal determination of his disability is being made. This provision, along with the absence of a waiting period under SSI, will intensify the need for obtaining medical evidence more rapidly so that disability determinations can be made promptly on claims filed by needy SSI applicants.

3. *Childhood Disability* With the implementation of the SSI program, the Social Security Administration will for the first time be responsible for disability evaluation and payment for children who are under the age of 18 years. A child of a family with limited income and resources will be found disabled if the child has a medically determinable physical or mental impairment which can be expected to result in

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*A 1925 graduate of the University of Louisville School of Medicine, J. Floyd Moorman, MD, is now Supervisor of the Disability Insurance Unit of the Department of Institutions, Social and Rehabilitative Services of the Oklahoma Public Welfare Commission of the State of Oklahoma. He is Associate Professor of Medicine emeritus of the University of Oklahoma Health Sciences Center. Doctor Moorman is a Fellow of the American College of Physicians and a Fellow of the American College of Chest Physicians.*



death or which has lasted or can be expected to last for at least 12 consecutive months and is of comparable severity to that which would prevent an adult from engaging in substantial gainful activity. The question of vocational assessment and concomitant ability to engage in substantial gainful activity is generally not relevant in evaluating disability during childhood because, in most situations, the child will not be of an age where he could reasonably be expected to enter the working population. Thus, in childhood cases, a finding of disability will be made solely on the basis of medical considerations including special medical criteria being developed for these cases within the above framework of consideration. There are, for example, severe impairments unique to childhood cases which are not now specifically described in the Social Security Listing of Impairments. The new medical criteria with appropriate signs, symptoms and laboratory findings are being formulated to evaluate these cases. There will also be a need for frequent pediatric reports under the new program. Similarly, there may be a need for the Oklahoma state disability determination unit to have pediatricians on its staff or at least available for consultation to review reports on these types of cases.

**4. Drug Addiction and Alcoholism** The law provides that a disabled person, who has also been medically determined to be a drug addict

or alcoholic, shall be eligible for SSI payments only if he is undergoing treatment appropriate for his condition as an addict or alcoholic at an approved institution or facility, if one is available. An eligible individual who has been medically determined to be a drug addict or alcoholic must receive benefits via a representative payee.

**5. Blindness** The criteria for establishing blindness under SSI are identical to those required to establish statutory blindness under the social security disability insurance program. Unlike Title II, however, engagement in substantial gainful activity will not preclude SSI payments if the statutory definition of blindness is met, although the SSI payments may be reduced under the income test. Also, since there is no duration requirement for blindness under SSI, there can be a favorable decision based on temporary blindness. Once again, the need for comprehensive and prompt medical reports must be underscored.

Implementation of the SSI program will undoubtedly give rise to new questions and point out areas of concern with respect to the medical community and the state agencies. If you have any further questions or desire additional information, please contact Doctor Floyd Moorman, Disability Insurance Unit, Department of Institutions, Social and Rehabilitative Services, Box 25352, Oklahoma City, Oklahoma 73125, or telephone A/C 405 521-1701. □

## INTERNAL MEDICINE REVIEW COURSE

1974

Every Wednesday 5:15 P.M. to 7:15 P.M.

West Lecture Hall Basic Science Education Building

Developed by

The Department of Medicine

Office of Continuing Medical Education for Physicians

University of Oklahoma

College of Medicine

Coordinator: Stephen D. Shappell, MD

January 16, 1974

TITLE: Gastroenterology III  
SPEAKER: William H. Hall, MD

January 23, 1974

TITLE: Pulmonary Disease I  
SPEAKER: Robert M. Rogers, MD

January 30, 1974

TITLE: Pulmonary Disease II  
SPEAKER: Robert M. Rogers, MD

February 6, 1974

TITLE: Current Concepts of Hematology  
SPEAKER: Walter H. Whitcomb, MD

February 13, 1974

TITLE: Glomerulopathies and Management  
with Steroids and Immunosuppression  
SPEAKERS: Anil K. Mandal, MD and  
Robert D. Lindeman, MD

February 20, 1974

TITLE: Changing Concepts in Management  
of Chronic Renal Failure with  
Dialysis and Transplantation  
SPEAKERS: Luci Antoniou, MD and  
J. A. Pederson, MD

February 27, 1974

TITLE: Annual Review of Infectious  
Disease: Anaerobic Infections  
SPEAKERS: Douglas W. Voth, MD and  
Harold G. Muchmore, MD

March 6, 1974

TITLE: Mycobacterial and Fungal Infections;  
Venereal Disease  
SPEAKERS: Harold G. Muchmore, MD and  
Ned B. Nichols, MD

March 13, 1974

TITLE: Metabolic Disorders Presenting in the Adult  
SPEAKER: Sylvia Bottomley, MD

March 20, 1974

TITLE: Solid Tumors  
SPEAKER: Richard Bottomley, MD



# *Statement on Venereal Diseases*

Council on Environmental, Occupational and Public Health of the American  
Medical Association

Gonorrhea ranks first (excluding influenza) and syphilis third among the reportable diseases in the United States. During 1972, there were 767,215 gonorrhea cases reported, 14.5% higher nationally than the previous year and more than double the number reported in 1965. Increases have occurred in all parts of the nation and in all age and sex groups, but the largest concentration of cases is in the 15-24 year age group. Allowance for both under reporting and failure to diagnose all cases as they occur suggests that the actual occurrence of gonorrhea infection last year was about 2.5 million.

The Center for Disease Control estimates that the reservoir of gonorrhea includes 600,000 to 800,000 females and about 100,000 males that are asymptomatic. To help reduce this reservoir of silent carriers, most states have implemented gonorrhea screening programs for females. The Center for Disease Control reports that from July 1972 to March 1973 there were 3,117,022 females screened and 158,604 (5.1%) had a positive test for gonorrhea. Of 664,110 females tested in private physician offices throughout the nation, 2.5% had a positive culture for gonorrhea. The Council urges medical societies to promote gonorrhea culture screening among females.

During 1972, syphilis morbidity (all stages) exceeded 91,000 reported cases. The number of congenital syphilitics under one year of age numbered 383 in 1972. Reported cases of primary and secondary syphilis (the infectious stages) numbered 24,429, up 3% from the previous year, with an estimated 85,000 cases

occurring annually. Because large numbers have escaped detection over the years, it is estimated that if every person in the United States could be tested for syphilis today, about ½ million previously untreated cases would be found.

An important procedure used to identify persons infected with syphilis or gonorrhea is laboratory reporting to public health authorities of those persons who have a positive test for either. The patient is contacted through his own physician for diagnosis and treatment if necessary. The following states do not have laws or health department regulations that require laboratories to report persons with positive VD tests to health authorities: Alaska, Idaho, Indiana, Louisiana, Maine, Massachusetts, North Dakota, South Dakota and Washington. Experience has shown that many laboratories refuse to report persons with a positive test for venereal disease to the health department until it is required by law or regulation. The Council recommends that medical societies in these states take appropriate action for the enactment of laws or regulations that require laboratories to report the positive venereal tests.

With the exception of Wisconsin, all the states now have laws or regulations permitting the treatment of minors for venereal disease without parental consent. It is believed, however, that some of the states' laws and regulations are so worded to make them inadequate. Also, some of the states might improve their laws by broadening the age group definition of minors.

Physicians in private practice treat approximately 80% of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea they treat. Physicians should assist public health departments by reporting the venereal disease cases they treat. Medical societies are urged to cooperate and give broad support to public health authorities. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea. Most state and some local health departments have venereal disease interviewer-investigators who can work confidentially with the patient and his contacts to determine the source and spread of his infection. The Council urges the physician to utilize the services of these trained investigators.

Adequate therapy of venereal disease, using the right forms and dosages of antibiotics, is essential. *Neisseria gonocorrhoeae* has shown the ability to develop resistance to penicillin

to the point where the recommended dosage now is 4.8 million units of aqueous procaine penicillin for the treatment of gonorrhea in both males and females. It is anticipated that additional changes in treatment may have to be made from time to time as increasing resistance becomes a problem or more effective antibiotics are discovered. For this reason the Council urges that medical societies impress upon their members the need for keeping abreast of changes in the recommended therapy of the venereal diseases.

The Council encourages the publication of more articles in professional journals on venereal disease and its control for the guidance of the profession. Medical societies are asked to support education of parents and the public through more extensive and imaginative use of all available media and through school curricula.

The Council urges medical societies to acquaint their membership with the growing and alarming dimensions of the venereal disease problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

535 N. Dearborn, Chicago, Illinois 60610



## OKLAHOMA MEDICAL SUMMIT

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The Oklahoma Academy of Family Physicians

May 13-15, 1974

AT THE MYRIAD

Oklahoma City, Oklahoma



## IMMUNE SERUM GLOBULIN FOR PREVENTION OF HEPATITIS-A

The agent that causes hepatitis-A in man is thought to be a virus. Although no vaccine is available, the administration of immune serum globulin (ISG) to exposed persons can afford a high degree of protection against hepatitis-A. After exposure, ISG should be administered as soon as possible. The appropriate dosage under most circumstances is 0.01 ml of ISG per pound of body weight. Exposure situations must be evaluated individually. The following guide is suggested:

**Household Contacts:** Contact as occurs among household residents is important in spreading hepatitis-A. ISG is recommended for household contacts who have not had hepatitis-A.

**School Contacts:** Although the highest prevalence of hepatitis-A is among school-age children, contact at school is seldom an important means of transmitting this disease. Routine ISG is *not* indicated.

**Institutional Contacts:** Conditions favoring transmission of hepatitis-A exist in institutions such as prisons and facilities for the mentally retarded. ISG administered to patient and staff contacts can limit the spread of disease in these circumstances.



## News From The Oklahoma State Department of Health

**Hospital Contacts:** Routine ISG administration to hospital personnel is not indicated.

**Office and Factory Contacts:** Routine ISG is not indicated for persons exposed in the usual office or factory situation.

**Common Source Exposures:** When a food or water vehicle is identified as a common source of infection, administration of ISG should be considered for all exposed.

**Pregnancy:** Pregnancy in itself should not alter ISG recommendations.

**Travelers to Foreign Countries:** The risk of hepatitis-A for U.S. residents traveling abroad varies with living conditions and hepatitis prevalence. Pre-exposure ISG is not recommended for travelers using ordinary tourist accommodations.

**Reactions:** Discomfort may occur at the sight of injection. A few instances of hypersensitivity have been reported. ISG should not be administered intravenously. □

### COMMUNICABLE DISEASES IN OKLAHOMA FOR NOVEMBER, 1973

Disease	November 1973	November 1972	October 1973	Total To Date 1973	Total To Date 1972
Amebiasis	1	2	2	29	27
Brucellosis	—	1	1	5	8
Chickenpox	15	10	3	1331	162
Encephalitis, Infectious	3	4	2	101	18
Gonorrhea (Use Form ODH-228)	654	646	826	9710	9057
Hepatitis, A,B, Unspecified	64	95	71	1053	825
Leptospirosis	—	—	—	—	—
Malaria	—	—	1	3	6
Meningococcal Infections	1	1	2	34	9
Meningitis, Aseptic	2	7	5	103	70
Mumps	10	3	13	468	164
Rabies in Animals	5	11	5	155	278
Rheumatic Fever	2	1	—	16	27
Rocky Mountain Spotted Fever	—	1	4	76	39
Rubella	1	4	—	182	43
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	5	2	1	61	10
Salmonellosis	15	11	47	263	147
Shigellosis	9	34	14	185	213
Syphilis, Infectious (Use Form ODH-228)	11	11	8	154	109
Tetanus	—	—	—	4	1
Tuberculosis, New Active	28	28	33	300	293
Tularemia	1	—	3	23	11
Typhoid Fever	—	—	—	2	3
Whooping Cough	—	3	—	21	35

## Peer Review Foundation Begins PSRO Study For OSMA

At the same time the federal government was announcing PSRO area designations, with Oklahoma being named a single statewide PSRO area, the OSMA Foundation for Peer Review, Inc., was beginning studies of PSRO possibilities or alternatives in Oklahoma.

The foundation itself was established about two years ago in response to the possibility that Professional Standard Review Organizations would be created. In May of last year the entire OSMA membership was polled and voted overwhelmingly to activate the foundation to "undertake preliminary investigation of the PSRO law and the forthcoming regulations, with the final decision to apply for PSRO involvement remaining vested with the OSMA House of Delegates." In mid-December the foundation's Board of Trustees met at the call of foundation President Hillard E. Denyer, MD, to organize their activities.

In a letter to OSMA President, C. Riley Strong, MD, Doctor Denyer stated, "We understand our mission to be one of developing information related to the operation of a PSRO-type peer review system in order that an informed decision can be made at a later date by the (OSMA) House of Delegates regarding the official stance to be taken by the association with respect to this law."

Doctor Denyer then went on to point out that no matter what decision was ultimately made by the association, the work being done by the foundation would be useful. He stated, (1) "If it is the decision of the OSMA for the Foundation to apply for PSRO designation, then we will have a substantial amount of preparatory work done toward the development of an optimum program within the constraints of the law and regulations; and, (2) if the association should stand against participation, the work of the foundation in analyzing the PSRO concept will provide a base from which PSRO repeal or modification, or a program of non-participation, can be justified in the light of onerous rules which might compromise the quality

of care or be deleterious to the rights of patients, physicians and health care institutions."

The foundation president pointed out that the directors of the foundation were not advocates of the PSRO law and that they clearly understood that their function was to serve in an investigative fashion only.

During the organizational meeting the foundation created six committees to carry out its functions. Of the six, two committees were given the highest priority: the Committee on Organization and Operation and the Committee on Guidelines for Care.

James B. Eskridge, III, MD, of Oklahoma City was asked to chair the Committee on Organization and Operation. The committee is to assess the institutional and professional claims volume of a PSRO in order to determine the needed capacity of a data processing system. It is to evaluate alternate computer application systems for mass screening of data, in order to select an optimum system for the peculiar needs of Oklahoma.

This committee is also charged with the development of a sound concept for PSRO implementation in Oklahoma, to be followed if such action is indicated by the OSMA House of Delegates. The main concept behind the program will be simplicity of operation and minimal aggravation to physicians, patients and institutions.

The committee's charge states, "Confidentiality of records should also be of prime concern. A process flow chart to illustrate the preferred concept should be prepared, personnel needs and cost estimates should be made, and all other operational matters should be identified and thoroughly analyzed in advance of the receipt of federal regulations and federal prototype recommendations."

The second priority committee is that on Guidelines for Care chaired by C. S. Lewis, Jr., MD, of Tulsa. This is the committee that will deal with "norms of care" as called for in the federal law. The committee charge states, "liaison should be established with all medical specialty groups and with other professional groups whose services are covered under Medicare and Medicaid. The purpose of the committee is to utilize the input of special interest groups in developing preliminary norms, standard and criteria *to be used as guidelines* in carrying out the requirements of the PSRO law . . . ie, medical necessity, length of stay,



quality and situs of care."

The guidelines for care committee has been instructed to develop a standardized format and definitions of terms in order that all special interest groups will be reporting and recommending in a uniform manner. The committee will have the responsibility of obtaining material from special interest groups, evaluating special interest input for objectivity, negotiating any necessary adjustments and to finally compile a manual of guidelines for consideration.

Other committees established by the foundation include the Constitution and Bylaws Committee chaired by Arnold G. Nelson, MD, of Midwest City. A Committee on Liaison with Other Health Organizations was established and Doctor Howard B. Keith, MD, Shattuck, agreed to serve as chairman.

Irwin H. Brown, MD, of Oklahoma City, will chair the Committee on Professional Education. A special Committee on Contingency Plans was created to be chaired by Rex E. Kenyon, MD, of Oklahoma City. This committee would "evaluate the prospects of PSRO repeal or modification and would develop recommendations regarding these courses of action."

The Foundation Board of Directors hope to have preliminary reports by early February. □

## Letter from Oklahoma Foundation For Peer Review

December 18, 1973

C. Riley Strong, MD  
Drawer 8  
El Reno, Oklahoma 73036

Dear Doctor Strong:

As you know, the Board of Directors of the Oklahoma Foundation for Peer Review, Incorporated, held an organizational meeting on December 15, 1973 in accordance with a directive from the OSMA Board of Trustees (October 28, 1973).

Our mission is to be based on the results of an opinion poll of the OSMA membership carried out in May, 1973, in which 1,075 respondents out of 1,290 voted affirmatively on the question: *"The Oklahoma Foundation for Peer Review should be activated to undertake preliminary investigation of the PSRO law and the forthcoming regulations, with the final decision to apply for PSRO involvement remaining vested with the OSMA House of Delegates."*

We understand our mission to be one of developing information related to the operation of a PSRO-type peer review system in order that an informed decision can be made at a later date by the House of Delegates regarding the official stance to be taken by the Association with respect to this law. Through investigation and preparation, our efforts can be utilized in any event, ie. (1) If it is the decision of the OSMA for the Foundation to apply for PSRO designation, then we will have a substantial amount of preparatory work done toward the development of an optimum program within the constraints of the law and regulations; and, (2) If the Association should stand against participation, the work of the Foundation in analyzing the PSRO concept will provide a base from which PSRO repeal or modification, or a program of non-participation can be justified in the light of onerous rules which might compromise the quality of care or be deleterious to the rights of patients, physicians and health care institutions.

The Directors of the Foundation are not advocates of the law. We understand very clearly that we are to serve only in an investigative fashion.

To carry out our mission, as described above, I have been asked by the Foundation Directors to borrow \$5,000 from the Oklahoma State Medical Association. The conditions of this loan, via the terms of this letter-contract, are:

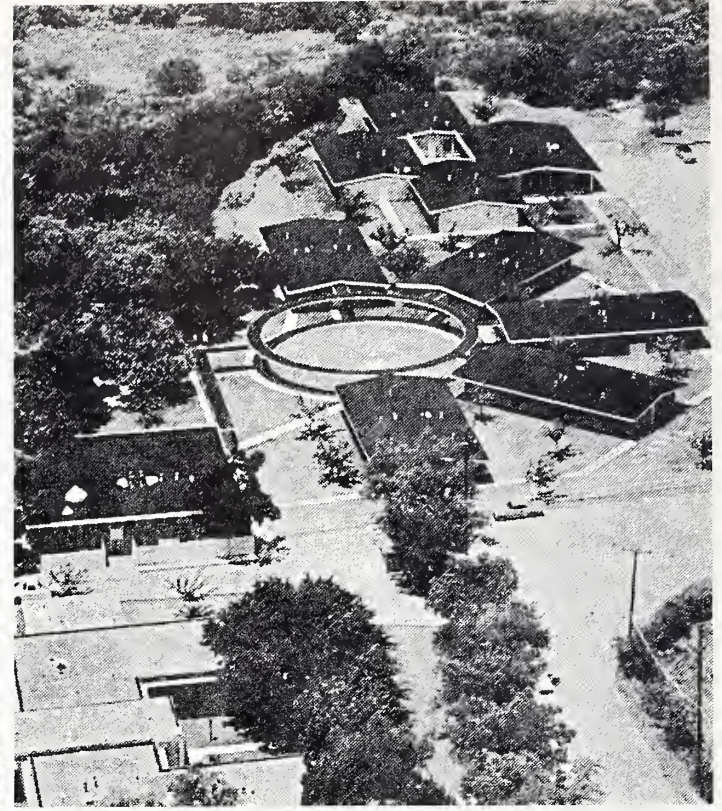
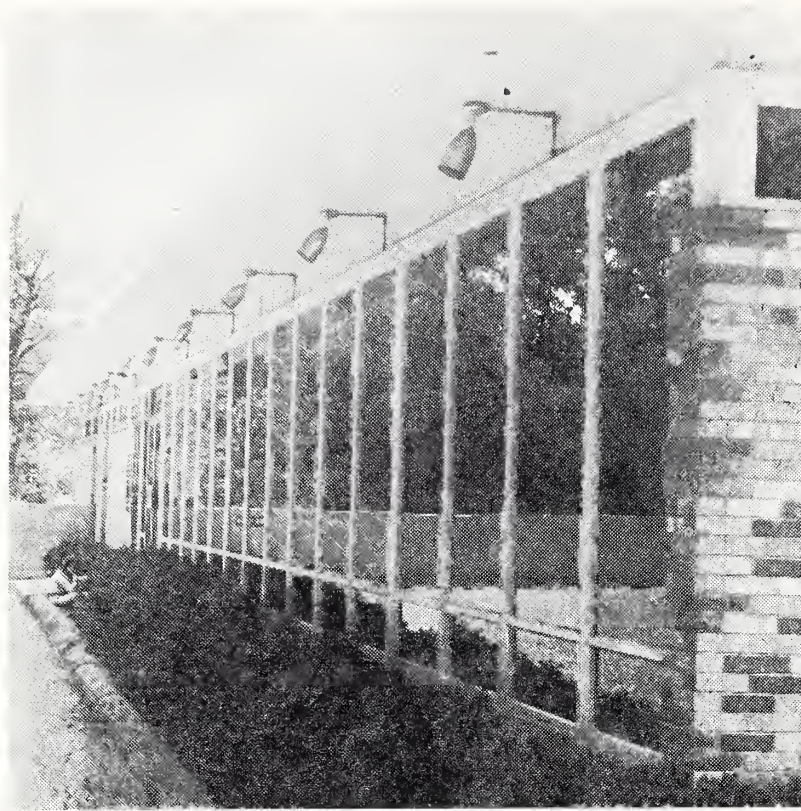
1. If it is the decision of the House of Delegates for the Foundation to apply for PSRO designation, and if this is successfully concluded, the Foundation will seek federal reimbursement for developmental costs, and funds thus received, if any, will be returned to the Association as payment in full of the loan. The loan shall be paid in full even though allowable federal reimbursement for expenses incurred may be less than actual.

2. If federal reimbursement is not obtained, due to federal policy or OSMA policy, repayment of the loan shall be forgiven in full.

If these terms are acceptable to the OSMA, please ask Mr. Don Blair to transfer \$5,000 from the accounts of the Association to the accounts of the Foundation.

Cordially,  
Hillard E. Denyer, MD, President  
Oklahoma Foundation for Peer  
Review





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## **"Killer — Trauma" Will Be Presented February 11th**

The next presentation in the series of medical documentaries presented by PBC-TV will be "Killer - Trauma" which is scheduled for February 11th, from 8:00 to 9:30 p.m. The programs have been designed to inform the public about the methods of prevention, early detection and treatment of five medical conditions which account for 75.7 percent of deaths in the United States.

The leading cause of death among Americans under the age of 40, accidents cause approximately 115,000 deaths a year, costing the public more than \$23 billion annually.

Accidents on the road, in fires, in the home, on the water, on ski slopes, and elsewhere—and the trauma that ensues—are a major health problem.

And the line between life and death is usually drawn by the emergency medical system closest to the accident victim.

Good emergency care treatment of the trauma victim in this country is spotty, a fact recognized by the American College of Surgeons which has a major program on trauma, and recently a group known as the American College of Emergency Physicians has been formed.

Trauma care requires an area-wide system with cooperation among city officials, hospital staffs, police departments, fire stations and citizens, as well as physicians. A few such systems are already proving successful—in Baltimore, Maryland, Jacksonville, Florida, and throughout the state of Illinois.

However, many more systems need to be put into effect. There is no other medical area where the combination of medical skills, political commitment and community involvement is more closely bound. In the Trauma show of "The Killers," new techniques developed to handle trauma, new institutions created to bring care to its victims, and new community action programs working to improve care are among the subjects to be covered.

Medical Advisory Board for Trauma: Doctor Merlin K. DuVal (vice president of medical affairs) University of Arizona; Doctor Oscar P. Hampton (director, trauma division) American College of Surgeons; Doctor Emilie Black (director, trauma division) National Institute

General Medical Sciences; Doctor James D. Mills (president) American College of Emergency Physicians; and, Doctor John Farguhar AMA Committee on Community Emergency Services. □

## **Thermostat Lowering Backed by AMA**

President Nixon's recommendation that thermostats be lowered to the mid-60s has drawn some support from the AMA. During his energy crisis presentation on television the President stated that the mid-60 thermostat setting was healthier than temperatures in the mid-70s. This statement drew some criticism at the time.

William Barclay, MD, Assistant Executive Vice-President for Scientific Affairs of the AMA has come out in support of the President's statement. He said, "Heating the interior of homes and offices during the winter removes moisture from the air. The higher the temperature, the dryer the air. Air with little moisture aggravates bronchial and other respiratory problems. It can contribute to dry throat and nose, coughs and dry skin."

Doctor Barclay went on to say, "The respiratory system doesn't cope well with the sudden change in temperature. Moving from an overly warm room into outside cold affects the body adversely, causing coughs and respiratory problems. The body adjusts to temperature changes gradually. We feel the cold more accurately on the first cold day in the fall than in January. We do not adapt well to abrupt temperature changes."

In concluding his statement the doctor pointed out that although there were no major health advantages to keeping inside temperatures lower, there were minor advantages that could add to the comfort and well being of individuals during the winter. □

## **AAMA Awards Two Scholarships**

The Oklahoma Chapter of the American Association of Medical Assistants, Inc. has awarded two \$100.00 scholarships to medical assistants students.

Teresa Findley, Ponca City, a sophomore at Northern Oklahoma College was one recipient and Vickie Banks, a Meeker sophomore at St. Gregory's College, received the other award.

The organization grants two scholarships each year. □

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## PSRO Hotly Debated During AMA Meeting

Meetings of the AMA's House of Delegates in Anaheim, California, were enlivened by hot debate over the association's policy on Professional Standard Review Organizations, known as PSROs. Meeting a total of nearly 15 hours, the House acted on 67 reports and 81 resolutions for a total of 140 items of business.

A total of ten resolutions concerning the PSRO law were introduced during the AMA's Clinical Session. Three of the resolutions were authored by the OSMA.

Other items considered by the AMA's House of Delegates included policy on the wage and price controls over physicians, funding of medical education, preadmission certification, quality assurance programs, health care for American Indians, and a national blood program.

The center of attention during the meeting was the debate over PSRO and the AMA's policy on the controversial program. Reference Committee A, which began its hearings on PSRO shortly before noon on Monday, December 3rd, heard more than four hours of testimony from physicians expressing various shades of opinion and did not complete its preliminary report until the early morning hours of Tuesday. Oklahoma physicians were among the most active testifiers before the reference committee and the OSMA delegates spoke extensively during two hours of debate on PSROs before the House of Delegates.

After the considerable debate, the AMA Delegates amended and then adopted the AMA Board of Trustees Report on PSROs in lieu of the various resolutions that had been submitted. The report outlined previous AMA policy in confronting the PSRO issue and closed with a statement that the House of Delegates recommend that the "AMA continue to exert its leadership and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations."

However, the amendment to the report urged, "That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential dilatorious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal,

modification, or interpretation of rules which will protect the public.

*"The considered opinion of this House of Delegates is that the best interest of the American people, our patients, would be served by the repeal of the present PSRO legislation. . . ."*

The amendment to the report pointed out that the medical profession remains firmly committed to the principles of peer review, so long as it is under professional direction and urged that any medical society peer review program that has proven effective be continued and not dismantled by PSRO implementation. It went on to encourage associations to work with local medical societies and hospital medical staffs to develop peer review programs based on "sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place . . .".

On the subject of Phase IV Wage-Price Controls, the House of Delegates considered four resolutions and two reports. The delegates adopted a substitute resolution which directs the AMA to continue, "as a matter of high priority," to seek relief for physicians from wage-price controls "using all available administrative resources," and that "the Board of Trustees be authorized to institute appropriate legal action when so advised by legal counsel."

Proposed government regulations which would impose a hospital pre-admission certification program for Medicare patients was opposed by the House. One resolution directed the AMA staff to take all steps necessary to prevent enactment of regulations mandating such programs and to determine whether or not such regulations would violate the Medicare law.

After considerable discussion, the delegates adopted a resolution that offers the American Hospital Association the cooperation of the AMA in deliberations on the AHA's Quality Assurance Program, known as QUAP. A final resolve in the resolution puts the AMA on record as disapproving of QUAP in its present form, but the association will seek the elimination of features it considers undesirable.

The development of a possible nationwide health insurance program for migrant workers was one of several proposals contained in a report of the Council on Medical Services approved by the House.



Problems related to maintaining the confidentiality of patient records were considered by the House in the report of the Council on Medical Services. The Council was instructed to prepare model legislation to preserve confidentiality as a guide to possible state legislation.

Proposed improvements in the Indian Health Service were considered by the House of Delegates, adopted, and referred to the Board of Trustees for further action.

The need for a national blood program was reiterated when the House endorsed a proposed AMA plan to implement the government's national blood policy by organizing blood banks and transfusion facilities within the national system that retains regional and local responsibility and authority.

Death was the subject of two items of action taken by the House of Delegates. Because of complex legal ramifications, the House adopted a policy position that at the present time a statutory definition of death is not desirable or necessary. State medical associations were asked to urge their legislators to postpone enactment of death statutes containing definitions. The House affirmed the statement, "Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria."

The second action dealing with death involved the "dying patient." The House adopted the following statement to serve as a guideline for physicians confronted with ethical problems related to euthanasia and death with dignity:

"The intentional termination of the life of one human being by another — mercy killing — is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

"The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

Medical malpractice problems were discussed by the House when it considered a report from the Board of Trustees summarizing the development of the new medical liability com-

mission formed by the AMA, the AHA, and several national medical specialty organizations. Delegates directed the Board of Trustees to "grant the highest priority for financial and organizational support" to the new commission. The commission itself will conduct the basic research in the field of medical liability in order to ease malpractice problems.

In other actions by the House, a resolution was referred to the AMA's Council on Medical Services which urged the AMA to oppose wide differences in fees for medical services performed by equally qualified physicians who practice in different geographic areas of the state. □

## Keogh Limit May be Increased

Legislation liberalizing tax treatment of retirement savings by the self-employed seems to be moving closer to Congressional enactment in the next session. A possibility exists that the Keogh limit may be upped to \$7,500 a year.

The House Ways and Means Committee has tentatively approved the Senate provision allowing self-employed people such as physicians, lawyers and dentists to claim tax deductions on \$7,500 a year, or 15% of income, for sums placed in a qualified pension plan. This compares with the previous Keogh limit of \$2,500 or ten percent of income.

During the 1973 Congressional session there was a threat of strict limitation on pension tax deferments in corporations, including professional service corporations. This threat now appears to have diminished with the way being clear for an easing of tax liabilities.

The Ways and Means Committee in general accepted the principle in the Senate bill of a \$7,500 annual limit on retirement benefit plans . . . so-called "Defined Benefit Plans." On defined contribution plans, which included profit sharing, money purchase, etc., the committee accepted the principle of a retirement benefit not to exceed 100 percent of the high three years of average compensation.

Prior to the final vote in the House Ways and Means Committee, organized labor had made a move to reduce tax deferral to a maximum of \$5,000 per year. Labor has been an arch enemy of the Keogh provisions. □



## College of Surgeons Set Houston Meeting

Eight postgraduate courses and two days of symposia, panels, lectures and motion pictures will highlight the second annual four-day, Spring meeting of the American College of Surgeons in Houston, March 25th-28th.

The four-day meeting will be held in Houston's Albert Thomas Convention Center and the Hyatt Regency Hotel. The eight post graduate courses, each nine hours in length, will involve plenary sessions, followed by splitting into smaller groups to facilitate participation of discussion. Physicians attending the meeting will actually have a chance to complete two nine hour courses by choosing one of four courses during the first two days of the meeting, and select another for the second two days of the meeting.

Postgraduate courses will cover fluids and electro-lights, cardiovascular surgery, cancer, plastic surgery, shock, gastrointestinal surgery, surgery of the hand, and urologic surgery.

Information on fees, housing and registration is available from the American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. □

## Wallstreet Journal Questions PSRO

Almost at the same time the AMA House of Delegates was hotly debating the association's position on PSRO, the prestigious Wallstreet Journal was editorializing against the program.

On December 6th in an editorial entitled "No Time for Patients?" the newspaper pointed out that PSROs "... will have the task of second-guessing decisions made by other doctors in treating patients under Medicare, Medicaid and maternal and child health problems."

The editorial went on, "While we favor a business like administration of federal social programs, the PSRO legislation raises some questions which didn't get adequately asked or answered by Congress. It was attached, by Senator Bennett (R., Utah), as a rider on to last fall's big and controversial Social Security bill and somehow rode through with almost no public attention. The House did not even hold public hearings on PSROs.

"And yet the law empowers the government, through PSROs, to examine medical records in

doctor's offices, not only of federally insured patients but private patients as well."

"Further," the Journal stated, "it can be doubted that Congress gave sufficient thought to the cost of all this monitoring and norm setting. There is no clear picture of how many PSROs there will be but a minimum of 150, and probably considerably more, is likely. The man-hours of doctors who serve on them will be that many fewer man-hours devoted to practicing medicine, not to mention the man-hours that will have to be devoted in doctor's offices to meeting demands for information or justifying decisions." The editorial went on to point out that there are 50,000,000 patients and 10,000,000 hospital admissions potentially subject to monitoring and then commented, "It makes you wonder if doctors will have any time left to treat patients."

In mid-December, well after the Wallstreet Journal editorial, HEW announced there would be 185 PSRO area designations throughout the United States. Twenty-five states were designated as PSRO areas along with the District of Columbia in the four territories. Oklahoma, along with its neighbors Arkansas, Colorado, Kansas and New Mexico, were in the 25. □



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## **Emergency Medical Systems Bill Signed by President**

President Nixon has signed into law a three-year, \$185,000,000 bill to help set up emergency medical units around the nation.

The bill authorizes grants and contracts for feasibility studies, planning, establishment, operation and expansion of emergency medical systems, known as EMSs, as well as research and training.

The bill had actually been on President Nixon's desk twice. The first time he criticized the bill in a veto, contending that existing federal and state programs were adequate to handle the problem. The veto led to a major confrontation with Congress last September in which the administration won when the house failed by a narrow margin to muster the required two-thirds vote to override the veto.

The administration's prime objection to the earlier bill was an amendment ordering that all public health service hospitals be kept open. The bill that the President signed into law in November did not contain that provision. However, the PHS hospitals were kept alive by a rider to a military appropriations bill that was subsequently signed into law.

During debate over the bill, representative Tim Lee Carter, MD, a Kentucky Republican said that the program would assist communities throughout the nation to develop and improve their emergency medical services systems and "contribute directly to saving tens of thousands of lives each year."

In another action of emergency medical services, the White House stated that it plans to designate enough radio frequencies for EMS purposes to serve the entire country.

Clay T. Whitehead, Director of the White House's office of Telecommunications Policy, says that this will be a vital first step in giving American communities the kind of integrated emergency medical services they need.

The administration plan calls for allocating 38 radio frequencies for emergency medical use throughout the United States. Whitehead said that 22 were already available, but on a much less standardized basis. Some of the others are now used by the Department of Defense and other federal agencies. Still others are used for highway call boxes, ski patrols and the like.

The administration noted that a few cities already have efficient systems including two-way communications between ambulance and hospital and radio equipment for sending vital data on the patient's condition from the scene of the emergency to doctors in a hospital. For most American communities, such arrangements are still nothing more than science fiction. □

## **Laboratory Proficiency Testing Promoted by OSMA**

PEP, the Proficiency Evaluation Program, developed by the College of American Pathologists will be the OSMA's approved laboratory proficiency testing program for 1974.

According to Raymond F. Hain, MD, Chairman of the OSMA Laboratory Quality Committee, "PEP has been expanded (and) there will be 108 opportunities to test specimens delivered eight times a year. These tests were selected as a result of surveys and experience in physician's office laboratories."

The PEP Program has been endorsed by the American College of Physicians and the American Academy of Family Physicians. It offers an inexpensive system for monitoring the capabilities of a doctor's office laboratory. It allows the physician to evaluate specific tests, reagents, and instruments for accuracy and precision. It also gives the physician a constant check of his laboratory techniques and personnel and assures him of quality test results.

Considerable concern by various government agencies has been expressed regarding the quality of medical laboratories, especially those in physician's private offices and clinics. Three states, California, Maryland and Arizona, have passed legislation requiring physician's office laboratories to participate in a state operated or state approved proficiency testing program. Similar legislation is being proposed in other states.

The PEP program has been used in Oklahoma for several years. In fact, Oklahoma was one of the first state medical associations to encourage its members to participate in the laboratory evaluation and testing program. The results of each evaluation is kept confidential and is for the exclusive use of the subscriber.



Specimens are sent eight times a year in March, April, May, June, September, October, November, and December. About four weeks after each specimen is tested and returned to the PEP Program the sender will receive a computer printout showing his test results and comparing them with the known constituents of the specimen tested.

The proficiency evaluation program is available to interested physicians for \$115 a year. Inquiries should be sent to the Proficiency Evaluation Program, College of American Pathologists, 230 North Michigan Avenue, Chicago, Illinois 60601. □

### **As Bad As They Are Malpractice Claims Are Few**

A medical malpractice incident is a relatively rare event according to a recent report from the HEW's Secretary's Commission on Medical Malpractice. While large lawsuit recoveries receive inordinate amounts of publicity, actual claims are rarer and jury trials are rarer still.

According to the HEW Secretary's statistics in 1970 a malpractice incident was alleged or reported for only one out of every 158,000 patient visits to physicians. In that same year a claim was asserted for only one out of every 226,000 patient visits.

While most doctors have never had a medical malpractice suit filed against them, those who have, rarely have been sued more than once. In 1970, 6.5 medical malpractice claims files were opened for every 100 active practitioners.

According to the statistics reported in the *AMA's Update*, most patients have never suffered a medical injury due to malpractice and fewer still have made a claim alleging malpractice. If the average person lives 70 years, he will have, based on 1970 data, approximately 400 contacts as a patient with physicians and dentists. The chances that he will assert a medical malpractice claim are one in 39,500.

Most hospitals, no matter how large, go through an entire year without having a single claim filed against them. Sixty-nine percent of 4,113 hospitals surveyed from June 1971 to June 1972 had not had a malpractice claim, 10 percent had had one, and 21 percent had had two or more.

A ten-year survey of claims experienced for

2,000 physicians in Maryland indicated that 84 percent had not been sued at all, 14 percent were sued once, and only two percent were sued more than once. □

### **Oklahoma MD Honored As Outstanding Young Woman**

An Oklahoma physician has been named one of the ten outstanding young women of America for 1973. Sara R. DePersio, MD, received the honor along with nine other young women in late November.

Each year the leading women's organizations honor ten young women between the ages of 21 and 35 for civic and professional achievement. Doctor DePersio is Chief of Maternal and Child Health Services for the Oklahoma State Department of Health. In this capacity she is responsible for the administration of all maternal and child health programs for the agency. Currently this includes maternity and family planning services, pediatric programs and child guidance programs.

A 1965 graduate of the University of Tennessee, Doctor DePersio served an internship in the field of public health, and residencies in preventive medicine and obstetrics and gynecology. She serves on several regional and national boards engaged in projects relating to childbirth, maternal mortality, planned parenthood and the incidents and consequences of rape.

The doctor is a clinical instructor in the Oklahoma Health Sciences Center and a member of the OSMA's Maternal Mortality Committee.

Young women honored each year are selected by a panel made up of the national presidents of major women's organizations. □

### **Correction**

An incorrect news article was carried in the November issue of *The Journal* of the Oklahoma State Medical Association on page 468.

In the article "Rubella in Oklahoma Striking Older Group" a statement was made implying that rubella is not preventable by immunization. Actually, rubella vaccines were licensed in 1969 and have been widely used.

*The Journal* regrets this error. □



## National Health Insurance Proposals Mount

Two more major national health insurance proposals have been thrown into the Congressional hopper, bringing the total to eight with at least two more waiting in the wings, including that of the administration.

Chairman of the House Commerce Committee, Harley O. Staggers (D-W. Va.) has introduced his own NHI proposal in predicting the hearings will be held on his bill soon. The second proposal came from Senate Republican leader Hugh Scott of Pennsylvania and Charles Percy, Republican from Illinois.

In other NHI activity, Senators Russell Long (D-La.) and Abraham Ribicoff (D-Conn.) have been looking around for high ranking House sponsors for their NHI bill. As a political courtesy Senator Long, Chairman of the Senate Finance Committee, offered the honor of being a joint sponsor to his House counterpart, Chairman Wilbur Mills (D-Ark.) of the House Ways and Means Committee.

Congressman Mills reminded Senator Long that he had informed all comers that he will not put his name on any NHI bill until after completion of the House hearings. With that formality out of the way, Senators Long and Ribicoff immediately began seeking other House sponsors.

Almost everyone in Washington has a different idea about when National Health Insurance will develop enough steam in Congress to actually be considered a possibility. In a special news analysis, American Medical News predicted that Congress will hold hearings on NHI in 1974, but won't get around to actual legislation. Congressional elections at the end of 1974 are the reason. Congressmen don't want a big money bill going through Congress just before an election. After the elections there will be a new Congress to convene in January, 1975. After such an election there is a go slow attitude while the new Congressmen become acclimated to Washington and get organized.

In short, the prognosis is that NHI will be taken up again, and possibly exploited, as an issue during the Presidential election year of 1976. The final NHI bill will probably be considered before the new president is elected.

A final version of the administration's NHI proposal should be out sometime during

January. In a December press conference HEW Secretary Casper W. Weinberger outlined the administrations thinking with regard to its proposals.

Weinberger stated that the President "remains fully committed to the idea that there has to be a comprehensive health insurance plan . . ."

Indications were that the proposal would mandate that employers offer health insurance policies that meet minimum standards to their employees. The program would have the federal government purchase coverage for the poor and for those who are high risk individuals. The plan would also provide equal benefits to all individuals who are covered, thus changing a feature of the previous administrative proposal which authorized lesser benefits for the poor than would be provided for the general population.

Secretary Weinberger also indicated that there would be cost sharing features and catastrophic illness protection coverage included. The catastrophic provisions would provide that families would not have to pay more than a certain percentage of their income for any total amount of illness. After that percentage had been paid, the program would pay all remaining costs for that illness. Weinberger also indicated that the bill would contain cost control features.

Congressman Staggers' National Comprehensive Health Benefits Act of 1973 would provide comprehensive health care benefits and complete protection against the cost of catastrophic illness to all. It would be financed by a combination of contributions from employers, the federal government and individuals, scaled to income. The federal funding portion would be for health insurance and catastrophic illness benefits for the poor and near poor.

Major features of the proposal, as described by Staggers, include a strong role for state governments in the development and administration of the program, incentives for the creation and use of Health Maintenance Organizations, a six year transitional period, the use of existing private health insurance carriers for administration, and the fact that the program builds on the existing health care system.

One interesting approach in the Staggers bill called for the creation of state health commissioners to be responsible for the actual administration of the program, including stan-



dard setting and quality control, assisting in development of Health Maintenance Organizations, and administration of some of the insurance provisions.

Senator Scott's two-part "Health Rights Act" would provide for inpatient protection for all persons suffering major illnesses, and would set up an outpatient Health Maintenance Insurance Plan. It would replace both the Medicare and Medicaid programs now in effect.

Under the Scott-Percy act, both the inpatient and the outpatient plans would be administered by insurance carriers or other public or private agencies on a regional basis, under contract with a new Office of Health Care within HEW.

The inpatient, "major illness" protection differs from traditional catastrophic plans by covering all costs above each families' health cost ceiling, which is determined by a formula taking into account both family income and family size. Money for the plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues.

The outpatient plan would be financed in part through family premium payments which would be supplemented in whole or part with

federal payments for low income families. Employers could arrange to finance all or part of their employees premiums.

The Scott-Percy Act would also establish a two-year, presidentially appointed "Health Delivery Committee" to study the current and long range needs for medical personnel and facilities. □

### **Myrtle Laughlin Memorial Lectureship Slated**

The Sixth Annual Myrtle Laughlin Memorial Lectureship in Hematology will be delivered at 4:00 p.m. in the Basic Science Building on the campus of the University of Oklahoma Health Sciences Center on January 17th, 1974.

Lecturer this year will be David G. Nathan, MD, Chief, Division of Hematology, Children's Hospital Medical Center, Boston. The title of his talk will be "Hydrocytes, Dessicytes and Hemolysis" and will be followed by a regional meeting of the Oklahoma Blood Club at 7:00 p.m. in the Faculty House in Oklahoma City.

Further information may be obtained from James W. Hampton, MD, Oklahoma Medical Research Foundation, 825 N.E. 13th Street, Oklahoma City 73104. □

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## Wichita, Kansas To Host Midwest Cancer Conference

"Current Concepts in the Clinical Management of Cancer" will be the topic of the two-day Midwest Cancer Conference scheduled for Wichita, Kansas, March 29th and 30th.

The Wichita meeting marks the 26th Annual Midwest Cancer Conference. This meeting, sponsored by the Kansas Division, American Cancer Society, is open to all physicians in the area.

The "Current Concept" theme will be carried throughout the meeting when such subjects as Management of Prostatic Carcinoma, Treatment of Breast Cancer, Therapy of Leukemia and Lymphoma, Female Genital Tract Cancer, and Surgical Therapy in Cancer.

Persons wishing more information are urged to contact the Kansas Division of the American Cancer Society, 824 Tyler Street, Topeka, Kansas 66612. ☐

## Auxiliary Launches ERF Project

"A million for millions" is the motto being used by the woman's auxiliary nationwide in order to raise \$1,000,000 for the American Medical Association's Education and Research Foundation. The OSMA's Auxiliary has set a minimum goal of a \$10 contribution per member.

AMA-ERF contributions are tax deductible since the purpose of the foundation is to foster medical education, medical research, and to assist young people in the financial aspects of their medical training. During 1971, grants totaling \$1,100,000 were made to 112 American and Canadian medical schools. During that same period 2,400 medical students, interns, and residents had loans guaranteed amounting to \$3,100,000.

Since it was established in 1962, AMA-ERF has guaranteed more than 46,000 loans totaling over \$51,000,000.

Contributions to AMA-ERF may be used as a memorial, to honor a friend or to remember an anniversary or a birthday. Contributions may be dedicated to a specific medical school through AMA-ERF. It is only necessary to send instructions with the contribution as to which school is to receive the money. The contribution is still tax deductible.

Contributions to AMA-ERF may be made in three different ways: (1) Contributions may be made to the county society woman's auxiliary in the county where the member resides.

(2) Donations may be sent to the state woman's auxiliary in care of the Oklahoma State Medical Association, Attention Mrs. Scott Hendren, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118.

(3) Contributions may be sent directly to the American Medical Association's AMA-ERF office at 535 North Dearborn Street, Chicago, Illinois 60610. ☐

## Notice For Expert Witness

The Forensic Science Foundation is currently conducting a research project the objective of which is to define and evaluate the various services performed by the forensic science profession in the criminal justice process.

If, since 1972, you have given reports or testimony in *criminal* court or elsewhere in the *criminal* justice process as an expert witness for either the prosecution or for the defense, would you mail a card or note to the Forensic Sciences Foundation giving your name, address and area of expertise. The foundation, in turn, will mail to you a short questionnaire designed to group your type and degree of involvement with other individuals who have similar expertise.

If you know others who should be included in this survey would you call their attention to this appeal for help?

It is emphasized that this is a federally sponsored research project. The results will not identify any individuals. No form of solicitation will result from your participation since all names, addresses and questionnaires will be treated as confidential information.

We urgently need your support and solicit your help.

Mail to: Forensic Sciences Foundation, 11400 Rockville Pike, Rockville, Maryland 20852. ☐

REMEMBER THESE DATES

May 12th-15th, 1974

OKLAHOMA MEDICAL SUMMIT



## Book Reviews

**Therapeutic Radiology; Rationale, Technique, Results.** WT Moss, MD, Professor of Radiology, Northwestern University School of Medicine, Department of Radiology, Chicago, Illinois. WN Brand, MD, Assistant Professor of Radiology, Northwestern University School of Medicine, Department of Radiology, Chicago, Illinois. Third Edition. Cloth, 564 pp, with 303 illustrations. St. Louis; The C. V. Mosby Co., 1969, \$24.50.

This book is the third edition of a superb textbook on basic radiation therapy, the first edition being printed in 1959. This issue has been considerably updated from the previous book and now includes new material and techniques.

Most of the material described in this book is broad enough to cover many of the general aspects of the treatment of cancer by radiation therapy, while specific enough to include some of the latest updated techniques, dosages, and treatment rationale.

The book is not written as a cookbook for radiation therapy and it is also not intended to be a complete treatise on the field of cancer. It serves as an excellent introductory book to selected clinical problems in therapeutic radiology and deals in some depth with the basic problems and the philosophy behind their management, yet passing somewhat superficially over the exact techniques of radiation therapy. This is a very worthwhile way of covering the material as it goes into enough depth and detail to enable a competent radiation therapist to utilize this book as a valuable source of reference material and yet the techniques of radiation therapy are dealt with superficially enough to prevent the amateur from utilizing this as a cookbook.

Doctors Moss and Brand have drawn heavily upon the experience of others and upon material presented in the literature. They bring the various chapters of the book up to modern standards of radiation therapy, with presentations that are accurate, brief, and clinically oriented.

The textbook covers in considerable detail most of the major areas of cancer occurrence within the body. These areas are broken up into specific regions such as oral cavity, lung, breast, male and female reproductive, etc. Each of these areas is then subdivided into the specific regions and the cancers that are most likely to form in these areas. The techniques

of management, not only by radiation therapy, but by surgery and chemotherapy or combinations of all three modalities are then discussed in detail.

In summary, the textbook is extremely well written and follows the techniques and formats that have been laid down in the previous two editions. This book has been a standard of radiation therapy since its initial printing in 1959 and I would totally recommend it as a must, not just for the radiation therapist, but for any physician who deals with cancer. *Carl R. Bogardus, Jr., MD*

**Preventive Medicine In World War II, Volume IX, Special Fields-Medical Department, United States Army.** Prepared and published under the direction of the Surgeon General United States Army. First edition cloth, 603 pp., with 132 illustrations. For sale by the superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price \$8.00.

Volumes comprising the official history of the medical department of the United States Army in World War II were prepared by the Historical Unit, United States Army Medical Department. These volumes are divided into two series: (1) The administrative or operational series; and (2) the professional, or clinical and technical series. This is one of the volumes published in the former series. The title Preventive Medicine was adopted for convenience to include subjects not readily classifiable in other volumes.

The book describes in detail the extraordinary scope and content of military preventive medicine in World War II. Traditional boundaries were transcended by activities which grew in all directions to meet the challenging situations of a global war and the problems of preservation and maintenance of health of troops in all parts of the world. An interesting inclusion is a description of the deficiencies in the training of medical and sanitary officers and enlisted men in preventive medicine, public health, hygiene, and tropical medicine. Most significant are the remedial actions taken by providing special courses of training, including seminars, professional meetings, demonstrations and practical exercises, and by the issuance of instructive materials.

In World War II, the Army became the largest

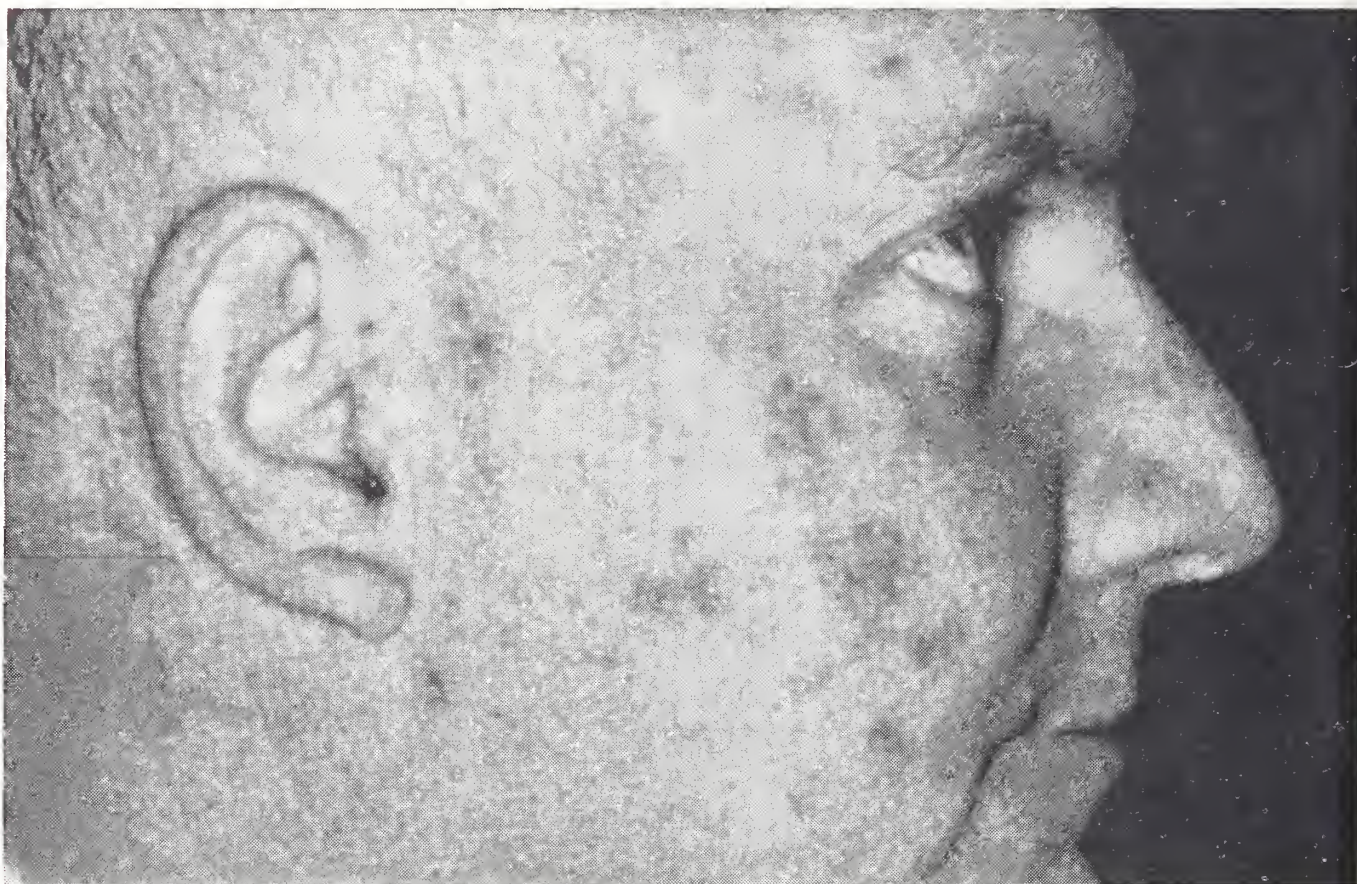
(Continued on Page xiv)



# What's on your patient's face...

may be more important than his chief complaint

Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electro-surgical procedures.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

\*Data on file,  
Hoffmann-La Roche  
Inc., Nutley, N.J





# The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

## Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

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Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

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**Contraindications:** Patients with known hypersensitivity to any of its components.

**Warnings:** If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

**Precautions:** If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

**Adverse Reactions:** Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

**Dosage and Administration:** Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

**How Supplied:** Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)-aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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## Book Reviews

(Continued from Page 34)

employer of civilian and military workers in factories, plants of all types, and a vast variety of manufacturing enterprises. To meet the resultant problems of health hazards, the Preventive Medicine Service, in collaboration with many agencies, developed an effective program for occupational health and industrial hygiene. These activities far exceeded any previous military or civilian effort in this special field. Of significance were the new investigative methods developed in an attempt to provide adequate indoctrination of officers and men in the field of Preventive Medicine. Medical laboratories of all types were developed and deployed globally. The description and evaluation of such extensive operations provides a notable and original contribution to history. For example, the acknowledged success of the special unit approach to a single disease such as malaria permitted the development of the concept of the Preventive Medicine Team which can be expected to remain in medical military doctrine ready to be expanded as needed to meet future crises.

During World War II health education came of age and the concept of continuing education in health and disease prevention for the military forces was developed. This involved the principle of imparting information about health and influencing the individual to act upon that information for the protection of his own health. In health education the individual must be informed of the necessity for carrying out a particular preventive measure and, further, be so convinced of its need that he carries it out whether or not there is someone at hand to force his compliance. For example, the program of venereal disease education developed in World War II was probably the most concentrated educational effort ever directed toward a single health problem, either in military or civilian history. In regard to occupational diseases military research changed from emphasis on causative factors to anticipation and correction of hazardous conditions.

Perhaps the ultimate purpose of this historical account is to assist succeeding generations to avoid the errors of their predecessors. It is through knowledge of past human experience that future mistakes may be averted. If the experiences of World War I had been remembered, or even if the experiences of World War

II itself had been more fully shared, much suffering and heavy military costs might have been prevented. The history of the Army's medical laboratories is unique and important because it describes the origins of some of this country's major achievements, clinical, research, and public health laboratory medicine.

The major advantages of this book apply chiefly in that it could serve as a basis for developing extensive preventive medicine procedures to deal with situations of local or national disasters. It could also serve as a basis for the development of plans to enlist the cooperation of selected local and national organizations for the sharing of civilian health officers with the military forces in times of emergency.

*Frank W. Bexfield* □

## Miscellaneous Advertisements

EXCELLENT OPPORTUNITY for general practice in nice community near Lake Eufaula. Privileges in modern 44-bed hospital. Space available for GP in clinic adjoining hospital that already has an abundant patient-load. Can expect full-time practice in a short time, along with time off coverage. Guaranteed starting salary — very rapid chance of advancement — with capabilities of earning up to \$50,000.00 yearly.

Call Carlton E. Smith, MD, 918 652-3337, Henryetta, Oklahoma, Collect.

BOARD CERTIFIED, 31-year-old pediatrician, would like partnership or group practice in Oklahoma with other pediatricians. Will complete military obligation in September, 1974. Contact Hal Vorse, MD, 130 Station Hospital, APO New York 09102.

PHYSICIAN WANTED. Opening on the staff of twelve multi-specialty doctors. Share responsibilities of pre-employment physicals, annual executive physicals and industrial injuries with another physician. The office is open 8:00 a.m. to 5:00 p.m., Monday through Friday. Contact Key M, *The Journal*, Oklahoma State Medical Association, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118. □



One of the most nutritionally vulnerable groups in our population is the elderly. Recent legislation to promote provision for special meals for this segment of our country attest to that fact. This significant minority is often easily overlooked, underestimated, or ignored. Statistics indicate that one of every ten persons in the United States is sixty-five years of age and older. That is twenty million people, five million of whom live alone.

Isolation from society occurs for a number of reasons: poor health, poverty, lack of transportation, feelings of rejection, a loss of a role in the social structure, and others.

What is the role of nutrition and nutrition education in this complex problem. There is a link. Lonely people fall into poor eating habits because they will not prepare meals for themselves. This, in turn, makes them feel more listless, isolated, and desolate. The Administration on Aging is trying to resolve this problem with appropriation of funds through grants to non-profit agencies and institutions to carry out projects to improve nutrition of the elderly. The goal of the program is to improve the "quality of life" of the noninstitutionalized elderly.

Auxilians across the nation are aware of this problem and many communities are involved with programs for the elderly, such as Volunteer Visiting Programs, Telephone Reassurance Programs, Home Delivered Meal Services and Group Meal Services, just to mention a few projects.

We have recognized the problem and we are taking action. In Oklahoma, we are examining the needs of our own communities. *Mrs. Zia Vargha (Camille), Nutrition Chairman, 1956 East 41st Street, Tulsa, Oklahoma 74105* □

## Safety Stressed

The main emphasis of safety this year is "Safety on the Streets." It was stressed at the southern regional meeting in Dallas that there are more and more preventable accidents on the streets that could be prevented if good safety habits were presented to the general public. There were several projects

that national is stressing on safety and I was very pleased to learn that the Oklahoma auxiliaries already have several of the projects in action. Oklahoma City auxiliary has the GEM program in use and this is the Good Emergency Mother program. This is the baby-sitter training program of the Woman's Auxiliary to the American Medical Association. It is felt that baby-sitting is a serious responsibility and that completion of a well-known course in child care is a definite must to qualify a sitter to be a good emergency mother substitute. If any of the other auxiliaries would like more information on this program I will be happy to send them pamphlets on how to establish this sort of program.

Another area concerning safety that was stressed was the area of poisonings. Tulsa County Medical Auxiliary with the help of Leo Lowbeer, MD, started the Poison Control Center at Hillcrest Medical Hospital and this has been in operation for about seven years and has proven to be very successful. The purpose of this center is to help in the recognition of poisonings and of the type of poison involved; to help in the treatment of poisoning; and to help in giving information by telephone to inquiring physicians and in the dissemination of knowledge and statistical data about poisoning. Hillcrest Poison Control Center is one of three similar centers in Oklahoma but is the only one serving the triple purpose of information, diagnosis and treatment. The other two centers are located in Ponca City and Oklahoma City. It is felt by both the doctors and the auxiliaries that this project has been very beneficial to the state and has definitely helped to decrease the number of poisonings.

I have had the Director of the Tulsa Area Safety Council, Mr. Bill Highland, prepare an excellent folder on all sorts of safety information and if anyone is interested in having one of these I will be happy to send them one if they will write to me. My address is *Mrs. Donald R. Bergman, State Safety Chairman, 6052 E. 56th Street, Tulsa, Oklahoma 74135.* □



**A Part A Medicare carrier change could be in the offing for Oklahoma.** The regional office of the Bureau of Health Insurance has sent letters to all hospitals for whom Oklahoma Blue Cross is presently intermediary, asking them to submit their nomination for Medicare intermediary. The letter explains that a contract has been successfully negotiated with the national Blue Cross Association making them eligible for nomination as an intermediary. Under the terms of this contract, the Blue Cross Association would place a representative in the Oklahoma Blue Cross office to serve as Medicare director. The letter does explain that other eligible intermediaries would include Aetna, Travelers and Mutual of Omaha. The Oklahoma Hospital Association is recommending that its members accept the National Blue Cross Association as intermediary.

**The cost of federal statistics seems awfully high.** According to AMA Update American taxpayers will pay an expected 21.7 million dollars during the current fiscal year for the Social Security administration's statistical activities. That's 39 percent more than we paid last year and 60 percent more than the year before.

**Petroleum shortages may cause another crisis.** Critical shortages of penicillin, cortisone and other vital drugs are forecast by the pharmaceutical industry unless more oil is diverted to the petro-chemical industry. Penicillin is especially scarce because petroleum base solvents, such as acetone and methanol are in short supply. As more crude oil is diverted for use as fuel-oil, the less there is available for petro-chemical products. Even the clothing industry is feeling the crunch, since most of the new fabrics are petroleum based.

**Another \$700,000,000 may be added to the annual cost of Medicare.** The United States Senate approved an amendment to a pending Social Security Bill that would expand benefits under the Medicare program to include payment for prescription drugs needed by persons with chronic illnesses who are not hospitalized. It is estimated to cost about \$700,000,000 annually to run the program.

**Being an incumbent may not be a big help in future elections.** Statistics show that

increasing numbers of Congressmen are not returning to Congress, and its not always a voluntary retirement. Since 1956, although the numbers have not been steadily increasing, there has been a substantial number of incumbents who did not return to office. In that year six incumbents were defeated in their primaries, 15 were knocked out in the general election, and 25 chose to retire. In 1972, 13 incumbents were defeated in the primaries, 13 were defeated in the general election, and 42 retired or ran for other offices. Political pundits are saying that 1974 may be the year for the political newcomers' chances to get into Congress. A number of early retirements have already been announced, plus the possible voter antagonism toward the present incumbent, no matter who he is, may add up to a whole new complexion in Congress.

**HEW may finally have discovered socioeconomic conditions as a factor in health.** The medical profession for years has been trying to tell Washington bureaucrats that the health care problems of the country cannot be solved with medicine alone. Apparently somebody finally understood the message because an HEW report said, "The socioeconomic analysis which has so far been undertaken strongly indicates that future gains in the health of the population are at least as likely to come from improvements in socioeconomic status as from biomedical advances." Now all we have to find out is how much those "socioeconomic analysis" costs us.

**Oklahoma Medical Summit will be highlighted with several social functions next May.** The joint meeting of the OSMA, the Academy of Family Physicians, and Oklahoma City Clinical Society scheduled for May 12-15 will include an early bird party at Oklahoma City's Gaslight Theatre on Sunday evening, an oyster party on Monday evening, and a gourmet dinner in the Petroleum Club on Tuesday evening. Entertainment during the dinner will be furnished by Mark Russell, an outstanding political satirist from Washington, D.C. □



## The Foreign Medical Graduate, A Blessing Or A Risk?

A recent television debate between HEW Secretary Caspar Weinberger and Health Subcommittee Chairman Paul Rogers regarding medical manpower has again brought into the limelight the problem of foreign medical graduates (FMGs). Rogers contends that there is a serious shortage of physicians in this country and that too much dependence in the solution of this problem has been placed on the ever-increasing number of FMGs. On the other hand, Weinberger, who is concerned with keeping federal support of medical schools to a minimum, expresses the view that the large number of FMGs and the moderately increased enrollment at American medical schools will solve the problem and thus avoid rising federal outlay. More recently, Doctor C. C. Edwards, the HEW Assistant Secretary for Health, even contended in a major policy speech that, in contrast to the expected shortage, we are facing in the next decade a physician surplus, relying of course — in addition to a conservative increase in the number of American graduates — on a heavy influx of FMGs. Doctor Edwards made it clear that the federal government is anxious to reduce its fiscal support of our medical schools as speedily as possible. Thus we can expect that the government will rely in the future to a considerably lesser extent on the increased output of our American medical schools and more than ever on a steadily increasing immigration of foreign physicians. This is also confirmed by the fact that the immigration laws have been relaxed for immigrating physicians.

What are the actual figures of foreign physicians that are coming to this country? In 1972, all together 14,476 physicians received initial licenses from the various State Boards of which 6,661 or roughly 45% were graduates of foreign medical schools. The United States Immigration Service reports that in the year 1971/1972,

11,427 foreign physicians entered the US, either as permanent residents, 7,144, or as exchange visitors, students and temporary workers. Most physicians in the latter categories are enrolled in graduate training programs or fellowships and a number of these will certainly change to a permanent resident status. A recent immigration law permits the exchange visitor to become a permanent immigrant without having to return to his home country, as was required previously. Approximately one-third of all interns and residents are FMGs, and 57% of residents serving in non-affiliated hospitals are likewise foreign graduates. In 1972/1973, there were approximately 22,000 foreign physicians serving as interns, residents or trainees as compared to 11,400 in 1963/1964, an increase of practically 100%. Emergency rooms, residencies and mental hospitals, particularly on the northeast and west coasts, could hardly be staffed without foreign physicians. While the latest figure of this year's American graduates reaches an all time high of 10,391, it is predicted that the number of immigrating foreign physicians is roughly equal, or—in the near future—may become equal to the total output of US medical schools.

This discussion of the admittance of FMGs opens up many questions. Would we consider it a satisfactory solution if half of this country's manpower needs for new judges, teachers, or policemen would be filled by people who have received their training outside this country? It seems unjustified to regard Representative Rogers' apprehension as to the admittance of large numbers of FMGs as "chauvinistic discrimination", as HEW Secretary Weinberger called it.

Those FMGs who have been accepted serve an important function in the US, as has been mentioned before. Eighteen percent of FMGs are members of medical faculties and have been characterized by the President of the State Medical Boards in the US as high caliber professionals who are desirable additions to American biomedical science and medicine. It is superfluous to state that the US traditionally opens its

## *Editorial /*

doors to political refugees, *eg* physicians from Cuba or Iron Curtain countries in Europe.

A future editorial will examine from what countries or regions the FMGs come and how their qualifications are tested and, if necessary, improved. To what extent are we contributing

to their integration into American medicine? Do those that return to their home country receive the appropriate postgraduate training in this country, which will make them better physicians after their return? Finally, we may question whether it is fair on the part of American medical authorities to drain the medical manpower pool of impoverished or underdeveloped countries. *Ernest Lachman, MD*

# **INFECTIONS IN THE PATIENT WITH RENAL AND URINARY TRACT DISEASE**

**WEDNESDAY, MARCH 13, 1974**

**PROGRAM FOR PHYSICIANS**

**Faculty House — 601 N. E. 14th Street**

**PROGRAM FOR ALLIED HEALTH PROFESSIONALS**

**The Everett Tower — Room C007 — 800 N. E. 13th Street**

This is the fifth successive year that a program dealing with renal and urinary tract disease will be presented in March. The emphasis in the physician's program this year will be on diagnosis and management of infection in the kidney and urinary tract and on the renal manifestations of systemic infection. Current recommendations on diagnosis and management of urinary tract infections, with the wide spectrum of antibiotics now available and with the various radiographic, isotopic and urologic techniques and procedures employed, are constantly changing. Three of the leading experts in this field in the country, a medical nephrologist, a pediatric nephrologist, and a urologist, are joined by a number of local resource physicians in discussing their current recommendations. Eight provocative case presentations will be utilized to initiate discussion on some of the areas of controversy. Each of the invited speakers also will give one formal presentation, the last being the fourth annual Paul Kimmelstiel Lecture.

A simultaneous session will be held for allied health professionals (nurses, dialysis technicians, dietitians, and social worker) oriented toward problems encountered by maintenance dialysis and transplantation patients.

Program coordinators:

Donna F. Conklin, R.N.	Robert D. Lindeman, M.D.	James E. Wenzl, M.D.
L. O. Laughlin, M.D.	Gatties L. McCulloch	William L. Parry, M.D.

Developed by

Department of Medicine — Department of Pediatrics — Department of Urology  
Office of Continuing Medical Education for Physicians  
University of Oklahoma College of Medicine

Sponsored by

Kidney Foundation of Oklahoma-Southern Kansas  
Oklahoma Regional Medical Program  
Association of University of Oklahoma Health Center Faculties





Today is a rainy, dreary day as I write this page to you. You might say this is the way I feel about many of the problems facing our profession today.

With Congress convening, we have the problem of trying to modify or repeal the PSRO law, if at all possible. In addition, I am sure there will be some sort of national health insurance passed by this Congress, as it may be politically expedient to the re-election of many lawmakers.

We must all be cognizant of the fact that we are losing an excellent Congressman, Clem McSpadden, who announced that he will run for Governor. We must be very diligent in supporting a candidate in that District who is favorable to the medical profession. Remember, too, that all six US Representatives must be elected every two years.

This is just a reminder to all of you that we must be more politically oriented. I am today authorizing some of our travel budget for attendance at the American Medical Political Action Committee meeting in Washington, March 15th-17th.

The Oklahoma Foundation for Peer Review Committee on Guidelines for Care, under the chairmanship of C. S. Lewis, MD, Tulsa, is working diligently on norms of care. These are being sent to all hospital staffs for their perusal, and medical specialty societies are being contacted to evaluate the norms in their fields of interest. This is extremely important to us and I wish to seek all of your help in going over these guidelines so that our Oklahoma medical community will have an input into the guidelines as medicine is practiced in Oklahoma. Doctor Jim Eskridge and his Committee on Organization and Operation is making progress in developing an optimum plan on the best possible implementation of the onerous PSRO law . . . if The House of Delegates should decide to do so.

Please be sure and mark time off on your calendars to attend the Oklahoma Medical Summit meeting, May 12th-15th, in Oklahoma City. The plans for this major medical convention are going along excellently. We will have

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excellent postgraduate education at this meeting, plus outstanding social events, sports activities, wet clinics and nearly 100 exhibits. We will also have as our guests, Doctor Roth, President of the AMA, and Doctor Jim Price, President of the American Academy of Family Physicians. Both of these men are very knowledgeable and their counsel and advice will be of great value to us as we look toward the future. You should hear them speak.

Last week I attended the Governor's Conference on Alcohol Highway Safety. This is a new program to get the chronic drinking driver off of the roads in Oklahoma. A chart on deaths by counties was extremely revealing to me. In one county in 1973, there were seven traffic deaths. All seven of them had a blood alcohol of over .10% (drunk by state law). Half of the entire traffic deaths in the state were attributed to the drinking driver. I hope that all of you will be interested and help support this program.

Your officers will attend this weekend, January 25th-27th, the AMA Leadership Conference. It is anticipated that at this time the AMA Board of Trustees will announce what they plan on doing about the House of Delegates mandate to repeal or modify PSRO . . . and to inform the public and the Congress about the deleterious effects this law will have on patient care. It is my opinion if the program announced by the AMA Board is only a half-hearted effort, Oklahoma should take the leadership in building a fire under them so that they will carry out the real intent of the House of Delegates. After all, Oklahoma is credited with getting this revolt started in Anaheim.

I again seek all of your support when it is needed on state legislation and national legislation. An informed group of physicians can make its voice heard if we all cooperate and work together.

Faternally,

*C Riley Strong MD.*

C. Riley Strong, MD



# Epidemiology of Kidney Cancer In Oklahoma

NABIH R. ASAL, PhD  
STANLEY W. FERGUSON, PhD

*A modest increase in the annual mortality rates for kidney cancer has been observed in Oklahoma since 1950, with the Indian males experiencing the unusually highest rates.*

## INTRODUCTION

Few reports have been published dealing with the epidemiology of cancer of the kidney. Data obtained from the third national cancer survey show that 1,356 new cases of kidney cancer were diagnosed during 1969. This constitutes about 1.8% of all cancer diagnosed in the United States during that year. The same survey reports an annual age-adjusted incidence rate of about 5.7 per 100,000 for the total population, or about 5.7 for whites and 5.2 for negroes. The age-adjusted incidence rates were 7.9 for males and 3.9 for females. Slightly higher rates were reported for the Western regions of the US (6.0) over the North (5.8) and South (4.8). Age-specific incidence rates show a peak in the <15 years-of-age, a gradual decline, then a subsequent increase with age after age 35.<sup>1</sup>

From The Department of Biostatistics and Epidemiology, The University of Oklahoma Health Sciences Center, where Dr. Asal is Associate Professor and from the Division of Epidemiology, Oklahoma State Health Department, where Dr. Ferguson is Director.

Mortality statistics dealing with malignancies of the kidney classified under ISC code 180 according to the 1955 revision and under ISC code 189 according to the 1965 revision include the following malignancies: Embryomas of the kidney, Grawitz's tumor, hypernephroma, Wilm's tumor, malignant papilloma of the kidney, and malignant neoplasms of the kidney or ureter not otherwise specified.<sup>2</sup> Hence, age-adjusted death rates combining all these cancers under one classification are highest for white males and lowest for nonwhite females and are about the same for white females and nonwhite males. The geographic distribution of white male mortality from kidney cancer indicates a cluster of states with increased death rates in Minnesota, Illinois, Wisconsin and New York, Connecticut and Massachusetts. The rates are generally decreased in the south and south midwest. For the male nonwhite, the rates are increased throughout the northeast and Great Lakes and decreased in the south. For white females, the rates are increased in New York, Michigan and the north midwest and decreased in the south. Clustering of increased rates in Massachusetts and New York appear for nonwhite females.<sup>3</sup>

International data are difficult to interpret since the rates for kidney cancer are included in the broad category, bladder, and other urinary organs.<sup>4</sup>

Several environmental carcinogens have



been suspected in the etiology of malignancies of the kidney, among these are: ionizing radiation, aromatic amines such as  $\alpha$  and  $\beta$  naphthylamine, and the hormone estrogen.<sup>5</sup>

The following report deals with the epidemiology of cancer of the kidney using Oklahoma mortality data registered from 1950-1970.

#### METHOD OF PROCEDURE

The data were obtained from death certificates filed in the office of vital statistics of the State Department of Health between 1950 and 1970 which indicated kidney cancer as the underlying cause of death. The data were analyzed according to sex, race and year of death to establish secular trends by year, as well as, for four five-year periods (1950-54, 1956-60, 1961-65, 1966-70).

Kidney cancer deaths and death rates by age, sex, and race for the twenty-year period, by five-year groups, are presented.

Populations at risk were estimated from the decennial census reports for Oklahoma. The Standard Mortality Ratio (SMR) was tabulated for each of the seventy-seven Oklahoma counties to delineate areas of high or low prevalence. The SMR was tabulated by dividing the observed deaths for a particular county during the 20-year period over an expected number of deaths for that county arrived at from the total mortality experience of the state and the proportion of people of the state living in that particular county. SMR above 100 should indicate

areas of elevated mortality, whereas, SMR less than 100 should indicate areas of low kidney cancer mortality. These ratios were tested for significance.<sup>9</sup>

Differences between the mortality experience of urban and rural populations were examined by grouping the counties of the state into metropolitan, non-metropolitan and rural. The male and female average annual age-adjusted death rates by county were ranked and tested for significance by the Kruskal-Wallis rank test.<sup>6</sup>

#### RESULTS AND DISCUSSION

Kidney cancer deaths and death rates by sex, race and year, as well as, annual deaths and rates for the total population from 1950 to 1970 are presented in Table 1. Average annual death rates by five-year periods and for the twenty-year study period are also shown. The average annual death rates for cancer of the kidney are 3.5 for males and 2.0 for females. The annual rates in both sexes reflect a slight increase over the twenty-year period. This increase is evident if we compare the 1950-54 and 1966-70 periods in term of number of deaths and rates. The calculated rates by race show the highest rates to occur among the Indian males (4.4) followed by white males (3.5); next, black males (2.9), white females (2.1) and black and Indian females at 1.4 each. Increases are indicated for all race and sex groups except for the Indian females. It is clear from the data that males are more at risk than females. The US data indicate an increase in risk for whites over nonwhites, however, the US nonwhite data were not subdivided further into Negro and Indian and comparisons made as in the case for the Oklahoma data. Generally, the Indian population experiences lower mortality from all cancer sites and the apparent increase in the mortality of the Indian males over blacks and whites is unusual. One explanation of this increase would be attributable to the selection of the denominator used in tabulating the rate, however, this phenomenon did not affect the rates among the females. A reasonable interpretation of the Oklahoma data would be a true increase in susceptibility of kidney cancer among the Indian males over the white and negro males.

The slight increases with time in kidney cancer mortality are consistent with the increased environmental carcinogens acting on renal tubular cells as is the case with other cancer sites.

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Table 1  
KIDNEY CANCER DEATHS<sup>+</sup> AND DEATH RATES BY SEX, RACE AND YEAR  
OKLAHOMA, 1950-1970  
(RATES PER 100,000 POPULATION)

Year of death	White		Black		Indian		Total Deaths	
	Male	Female	Male	Female	Male	Female	Male	Female
1950	2.4 (24)	2.0 (20)	2.8 (2)	0.0 (0)	7.4 (2)	0.0 (0)	2.5 (28)	1.8 (20)
1951	2.1 (21)	1.8 (18)	2.8 (2)	2.7 (2)	0.0 (0)	3.7 (1)	2.1 (23)	2.0 (22)**
1952	2.3 (23)	2.0 (20)	1.4 (1)	2.6 (2)	3.6 (1)	3.6 (1)	2.2 (25)	2.0 (23)
1953	2.6 (27)	1.8 (14)	1.4 (1)	0.0 (0)	3.5 (1)	0.0 (0)	2.6 (24)	1.7 (14)
1954	4.0 (41)	2.1 (22)	1.4 (1)	0.0 (0)	0.0 (0)	0.0 (0)	3.7 (42)	1.9 (22)
1950-1954	2.6*(136)	1.9*(99)	2.0*(3)	1.1*(4)	2.9*(4)	1.4*(2)	2.6*(147)	1.9*(106)
1956	3.5 (36)	1.9 (20)	1.4 (1)	0.0 (0)	0.0 (0)	6.6 (2)	3.3 (37)	1.9 (22)
1957	2.6 (27)	1.9 (20)	1.4 (1)	0.0 (0)	3.3 (1)	3.2 (1)	2.6 (29)	1.8 (21)
1958	2.8 (29)	1.4 (15)	2.8 (2)	1.3 (1)	6.5 (2)	0.0 (0)	2.9 (33)	1.4 (16)
1959	3.5 (36)	2.1 (22)	6.8 (5)	1.3 (1)	0.0 (0)	0.0 (0)	3.6 (41)	2.0 (23)
1960	4.7 (49)	1.3 (14)	1.4 (1)	2.5 (2)	6.3 (2)	3.1 (1)	4.5 (52)	1.4 (17)
1956-1960	3.4*(177)	1.7*(91)	2.8*(10)	1.0*(4)	3.2*(5)	2.5*(4)	3.4*(192)	1.7*(99)
1961	3.9 (41)	2.6 (28)	2.7 (2)	3.7 (3)	3.0 (1)	0.0 (0)	3.8 (44)	2.6 (31)
1962	3.4 (36)	1.8 (20)	0.0 (0)	3.7 (3)	5.7 (2)	0.0 (0)	3.3 (38)	1.9 (23)
1963	3.9 (41)	2.2 (24)	5.3 (4)	0.0 (0)	2.7 (1)	0.0 (0)	3.9 (46)	2.0 (24)
1964	5.4 (58)	2.5 (28)	2.6 (2)	0.0 (0)	5.2 (2)	0.0 (0)	5.2 (62)	2.3 (28)
1965	3.3 (36)	1.8 (20)	1.3 (1)	1.2 (1)	7.5 (3)	0.0 (0)	3.4 (40)	1.7 (21)
1961-1965	4.0*(212)	2.2*(120)	2.4*(9)	1.8*(7)	4.9*(9)	0.0*(0)	3.9*(230)	2.1*(127)
1966	4.2 (46)	2.1 (24)	3.8 (3)	1.2 (1)	7.3 (3)	0.0 (0)	4.3 (52)	2.0 (25)
1967	3.9 (43)	2.3 (26)	1.3 (1)	2.3 (2)	4.7 (2)	2.2 (1)	3.8 (46)	2.3 (29)
1968	3.8 (42)	2.1 (24)	7.5 (6)	0.0 (0)	4.5 (2)	0.0*(0)	4.1 (50)	1.9 (24)
1969	2.8 (31)	2.3 (27)	2.5 (2)	2.2 (2)	2.2 (1)	2.0 (1)	2.8 (34)	2.3 (30)
1970	4.5 (50)	2.2 (26)	6.2 (5)	4.4 (4)	4.2 (2)	2.0 (1)	4.6 (57)	2.4 (31)
1966-1970	3.9*(212)	2.2*(127)	4.3*(17)	1.8*(8)	4.5*(10)	1.3*(3)	3.9*(239)	2.2*(138)
1950-1970	3.5*(737)	2.1*(437)	2.9*(43)	1.4*(23)	4.4*(28)	1.4*(9)	3.5*(808)	2.0*(470)

\*Average Annual Rate

\*\*One female, race unknown

+deaths are in parenthesis

Table 2 presents age-sex-race specific death rates as well as adjusted rates. The most obvious observation is the peak in mortality experienced in the very young, the decline afterward and the subsequent increase after age 35. The adjusted rates show a slight increase for white males, a stable rate for white females and a substantial increase for nonwhite males and females.

The age specific curve suggests differing etiologies of kidney cancer in infancy, early childhood and those operating during the rest of life. Those cancers of the kidney occurring in infancy are perhaps congenital. Miller *et al*,<sup>7</sup> reported as "impressive" the evidence of the

excessive occurrence of kidney cancer with congenital malformations and concluded that these tumors may be enhanced by teratogenic influences. Later, Rawls and Melnick<sup>8</sup> attempted to explain this phenomenon by suggesting that congenital defects may be brought about by congenital infection with rubella virus. They did suggest that organs of children of these mothers are made of fewer cells than normal children. This, they concluded, may explain the increased susceptibility to carcinogens. This increased susceptibility may explain the higher rates in males and in whites as these groups have more of a tendency for occupational exposure to atomic energy plants, radium and



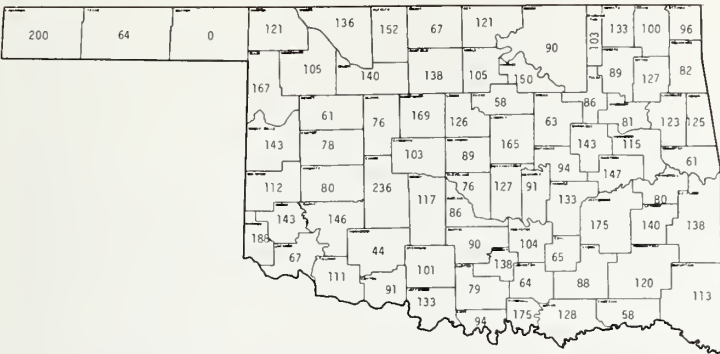


Figure 1. Standard Mortality Ratios of Kidney Cancer in Oklahoma by County, 1950-1970.

uranium mines and radiotherapy and diagnosis.

The mean average annual age-adjusted death rates by sex for the white population and degree of urbanization which appeared in Table 3 suggests a significant increase in mortality from kidney cancer with degree of urbanization for both males and females. This finding is consistent with the tendency for most cancers to occur in higher frequency in urban communities. The urban life and environment seem to increase the susceptibility of people to cancer of the kidney.

In Figure 1 the geographic distribution of mortality from kidney cancer is expressed using standard mortality ratios. It is obvious that high prevalence, as well as, low prevalence counties are represented in all geographic areas of the state. However, several counties experienced unusually high ratios and are worthy of mention here. The counties of Caddo (SMR 236), Cimarron (SMR 200), Harmon (SMR 188), Marshall (SMR 175), Pittsburg (SMR 175), Kingfisher (SMR 169), Ellis (SMR 167), and Alfalfa (SMR 152) experienced mortality in excess of 50% than was expected. Also noticeable was the absence of kidney cancer deaths in Beaver County and the very low deaths in Comanche county (SMR 44). Discussion of the reasons behind the geographic distribution of malignancies of the kidney is beyond the scope of this report. However, more information about counties with unusually high or low rates ( $\pm 50\%$ ) appears in Table 4. It is worth noting that except for Caddo, Pittsburg and Comanche counties the excess of observed mortality over expected in all of these counties is about two to four cases. Therefore it is not unusual for sparsely populated counties experiencing few deaths to show unusually high standard ratios with an increase of few deaths (two to four) over a 20-year period.

The excess in observed deaths for Caddo

Table 2  
Age-Sex-Race Death Rates For Kidney Cancer  
Oklahoma: 1950-1970  
(Rates Per 100,000 Population)

Age	White Male				White Female			
	1950-54	1956-60	1961-65	1966-70	1950-54	1956-60	1961-65	1966-70
<5	7.3	6.4	3.7	1.1	3.8	1.9	2.9	0.0
5-14	1.0	0.0	0.9	0.4	1.1	1.0	0.0	0.9
15-24	0.6	0.0	0.0	0.5	0.6	0.0	0.7	0.5
25-34	0.7	0.7	1.6	0.7	1.3	0.7	0.0	1.4
35-44	6.6	7.6	8.5	5.4	2.8	5.1	3.7	5.1
45-54	19.4	17.6	22.6	17.1	3.4	4.8	10.6	8.8
55-64	41.4	53.7	63.0	49.9	16.7	13.0	21.2	17.3
65-74	66.4	82.5	87.3	94.6	53.8	40.0	30.1	34.7
75+	54.0	83.0	105.3	120.4	93.1	66.8	92.6	82.6
AADR*	14.2	16.9	19.6	18.8	9.9	7.8	9.3	9.4

Age	Non-White Male				Non-White Female			
	1950-54	1956-60	1961-65	1966-70	1950-54	1956-60	1961-65	1966-70
<5	7.4	0.0	0.0	0.0	14.8	0.0	0.0	0.0
5-14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.1
15-24	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
25-34	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
35-44	26.8	19.1	0.0	17.9	15.1	0.0	0.0	7.2
45-54	9.9	19.9	40.0	46.5	9.1	0.0	0.0	7.8
55-64	53.2	85.0	56.6	62.7	0.0	22.6	30.1	42.9
65-74	34.5	32.9	63.3	107.3	0.0	47.2	29.5	11.1
75+	0.0	90.9	133.3	144.7	39.4	59.5	49.5	38.1
AADR*	12.3	17.8	18.7	26.4	5.8	7.2	6.4	9.3

\* Age Adjusted Death Rates based on the 1960 State White Males as the standard population.

county is about 21 cases. This is a significant increase ( $p < .01$ ) as only 16 cases were expected and 37 observed. This increase in Caddo County was accompanied by a substantial decrease (not statistically significant) in the observed over the expected deaths in Comanche County. Actually, during the 20-year period about 50 deaths were expected and only 22 observed, a total decrease of about 28 deaths. It is likely that since both of these counties are adjacent to one another that the availability of diagnostic facilities in either of the counties may have contributed to this phenomenon. However, the population of Comanche county is about 90,000 whereas that of Caddo County

Table 3  
Mean Average Annual Age-Adjusted Death Rates  
by Sex of White Population and Degree of  
Urbanization for Oklahoma Counties, 1956-65

Cancer Site	Degree of Urbanization			Kruskall-Wallis Test	
	Metropolitan	Non-Metro-politan	Rural		
	Sex	Mean	Mean	Mean	
Kidney Cancer	Male	4.2	3.7	3.1	9.08*
	Female	2.0	1.5	1.6	8.09*

\*Chi-square Values  $p < 0.05$



TABLE 4

Observed and Expected Number of Cases of  
Counties Experiencing Unusually High or Low  
Standard Mortality Ratios Kidney Cancer, Oklahoma

County	Number of Cases		Standard Mortality Ratio [(Observed/expected) 100]
	Expected	Observed	
Alfalfa	4.6	7	152
Caddo*	15.7	37	236**
Cimarron	2.5	5	200
Ellis	3	5	167
Harmon	3.2	6	188
Kingfisher	5.9	10	169
Marshall	4.0	7	175
Pittsburg	18.9	33	175**
Beaver	3.9	0	0
Comanche*	49.9	22	44

\*Adjacent Counties

\*\*Significant at  $p < .01$

about 30,000. The reported increase in Caddo County and decrease in Comanche County is not consistent with the reported elevation of

mortality from kidney cancer in metropolitan counties of Oklahoma over non-metropolitan and rural counties. Pittsburg County also reported a statistically significant ( $p < .01$ ) increase in the observed deaths over expected. The county has about 34,000 population and certainly cannot be considered an urban county. The mortality from kidney cancer in Comanche and Caddo Counties as well as in Pittsburg County needs to be investigated further.

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P.O. Box 26901, Oklahoma City, Oklahoma 73190.

## AMERICAN BOARD OF FAMILY PRACTICE

### Announces

### Certification Examination

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 19th-20th, 1974. It will be held in five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing: Nicholas J. Pixacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

*Important Note:* It is necessary for each physician desiring to take the examination to file a completed application with the board office. Deadline for receipt of applications in this office is June 15th, 1974. ☐



# The Beginning of Medical Organization In Oklahoma, 1889-1893

R. PALMER HOWARD, MD  
ROSE C. GIDEON, MD

*The first medical society meeting took place in Oklahoma "City" in June, 1889, within seven weeks of the opening of Oklahoma Territory.*

The fertile lands west of Arkansas and north of the Red River were set aside in the 1830's to be a permanent home for Indians. Later, the Kansas Territory defined a northern border of the territory. Many of the semi-autonomous nations in Indian Territory joined the Confederacy in the War Between the States. Also, in the 1860's the nomads of the plains who raided the Colorado bound caravans and frontier posts imposed a stubborn barrier to the western surge of white settlement. These factors molded the postwar federal policy. New treaties with the Creeks and others of the Five Civilized Tribes freed much land for the settlement of other Indians. The Southern Plains Indians were relocated in the western part. In the center of the territory, however, an area of rich grassland served only for traveling herds of Texas cattle. Would-be settlers, called

"Boomers," dramatized their cause by founding short-lived Oklahoma colonies. Political pressure on Congress to open the area mounted. Early in 1889, the federal government cleared the title to the unassigned lands by making additional payments to the Creek and Seminole tribes, and President Benjamin Harrison proclaimed the date of the land opening. The borders of the two million acres were guarded by cavalry troops against early immigrants ("Sooners"). On a prearranged signal the troops allowed the waiting pioneers to enter the new land and establish claims.

Ambitious men from many backgrounds made the run on April 22, 1889, or joined the rush in the following months into the "unassigned lands" of Indian Territory. This unnamed area was soon called Oklahoma. Within it were Guthrie and Oklahoma Station on the Santa Fe Railroad, and Kingfisher on the Chisholm Trail. The holdings of the Cherokee, Creek, Seminole, Choctaw, Chickasaw, Osage, and several Indian tribes recently transferred from Kansas, surrounded the new pioneer settlements on the north, east, and south. The extensive reservations of the Plains Indians lay to the west.<sup>1</sup>

During the first year following the "run," there was widespread lawlessness often pre-



cipitated by disputes about land claims and commercial privileges. Federal marshals and scattered military units attempted to keep order with limited success. Provisional civil governments were initiated, but lacked authorization. On May 2, 1890, Congress passed the Oklahoma Organic Act, which defined the territory as the six central counties (Cleveland, Oklahoma, Logan, Payne, Kingfisher, Canadian) and the public land strip, or "No Man's Land," north of the Texas panhandle. Guthrie was designated the capital. The 1890 census recorded 4,151 people in Oklahoma [City] and 5,323 in Guthrie. The commercial ambitions of Oklahoma City citizens were whetted by the initiation in 1890 of the Choctaw Railroad. Eventually, its passage provided an east-west link with both the Santa Fe Railroad at Oklahoma City and the recently opened north-south Rock Island line at El Reno. Territorial and urban populations grew in the next decade, as openings to white settlement of the Cherokee outlet along the Kansas border and the federally administered reservations ex-

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*Doctor Howard is a Fellow of the American College of Physicians, a member of the Central Society for Clinical Research, the Endocrine Society, the American Association for History of Medicine, the American Historical Association, the Western History Association, and the Oklahoma Historical Society.*

*Oklahoma State University in 1968 and her MD degree from the University of Oklahoma School of Medicine. During a vacation in her junior medical year she received a fellowship from the Student Council of the College of Medicine to work on this project. She was president of the Health Sciences Center History of Medicine Society, 1971-1972. Doctor Gideon is currently a resident in radiology at the University of Oklahoma Health Sciences Center.*

panded Oklahoma Territory to the western borders of the present state.<sup>1</sup>

The designation "Oklahoma" could refer to city, county, territory, or state. Prior to passage of the Organic Act, Oklahoma was the name of both an unorganized pioneer district and a town in Indian Territory. After that time Oklahoma was also the name of the territory which encompassed a town and county of the same name. On July 15, 1890, by territorial authority the town was incorporated, and was usually called Oklahoma City.<sup>2</sup>

The color and turmoil associated with the start of commercial and professional activities in the city are apparent in the pages of *The Oklahoma Gazette*, which began publication as a daily paper in Oklahoma on May 21, 1889. Within six weeks of the April opening, the multitude of tents around Oklahoma Station had given way to many frame and a few brick structures in the central blocks of the town. Early on a June morning in 1889, when "Main street and Grand avenue have been entirely graded and California and Broadway partially, . . . ten men left the Gazette office to take the first census of Oklahoma. . . . No houses outside the platted limits were counted. . . ." They enumerated 1,603 occupied buildings (including 1,131 completely or partially of frame construction, and 472 tents) and 4,138 inhabitants, of whom 2,681 were men, 721 women, and 736 children. The relatively high proportion of women and children in a newly opened frontier town was considered as a measure of confidence in its future growth and prosperity. That the optimism spread to health practitioners is supported by the report that there were 21 drug stores, two dentists, 45 doctors, and "two female doctors."<sup>3</sup> These numbers appear relatively large for the population of the town, but it was a main rail distribution point for an expanding area.

Graduate physicians of the regular and sectarian schools, diploma-mill practitioners, druggists, and professed healers of every type competed for patronage in the unorganized frontier settlements. After the basic needs of food and shelter were satisfied, thoughtful laymen and health professionals turned their attention to the proper care of acute illnesses, births, surgical emergencies, and the enforcement of sanitary measures. Even before the establishment of the territorial government and the enactment of public health legislation, the doctors formed societies.



The existence of professional organizations in Oklahoma Territory before May 1893 was not mentioned, however, in the published history of the Oklahoma State Medical Association.<sup>4</sup> The original minutes of the Oklahoma Medical Society, 1890-1893, in a battered 7½ x 10 inch exercise book were recently discovered in a secondhand store in Bethany, Oklahoma. The finder thoughtfully purchased the book as a gift for his physician, who then donated it to the University of Oklahoma.<sup>5</sup> These minutes and the early newspapers, directories and similar reports, have revealed the relationship between this society and the medical associations in the twin territories. In addition, the existence of a still earlier "Oklahoma Medical Society" has been uncovered.

In the intense competition of pioneer life in Oklahoma City, the advantage in providing health care apparently lay with the drug stores, especially those with doctors' offices on the premises. Some of the regular physicians undoubtedly compounded their own medicines, but many preferred to have prescriptions filled by independent druggists. Before the end of May 1889, these difficulties prompted letters in the newspapers from physicians who desired to practice their profession alone or in association with druggists. One doctor wrote:

TO PHYSICIANS OF THIS CITY. In the issue of the Gazette of the 27th I read Doctors Wood & Woods' notice to doctors. I concur in their views, except when they include all druggists. There are a very few druggists here who have no physicians with them. While a fraternal feeling should be cultivated between the accredited members of our profession, still I will send no prescription to a drug store having a physician connected therewith, and if I were the druggist I could not reasonably expect patronage from any physician not connected with my store.

My views are given with the most friendly feelings towards all. A meeting of the members of our profession should be called as suggested by Drs. Wood & Woods. Fraternally Yours, C. B. Bradford, M.D.<sup>6</sup>

The suggestion to hold an open meeting soon gained support from a group of doctors interested in professional organization. The following notice was published:

Attention Doctors. Seeing the communications of Doctors Wood & Woods

and Doctor Bradford, we think it would be well to call a meeting of the physicians of Oklahoma City for the purpose of getting acquainted, to establish a fee bill and take into consideration the advisability of forming a Medical Society, and any other business that will be for our mutual benefit.

We will meet at Dr. Bradford's office on Main Street, three blocks west of Railroad street, south side, at 8 o'clock Tuesday evening, June 4th. All physicians are requested to attend. H. C. Way, M.D., C. B. Bradford, M.D., H. B. Woods, M.D., J. W. [I. W.] Folsom, M.D., L. W. Benepe, M.D., V. A. Wood, M.D., D. D. Halstead, M.D.<sup>7</sup> About fifteen physicians assembled on June 4, 1889, and appointed a committee of four, including Doctors C. B. Bradford and Delos Walker, to draft the constitution and bylaws of the proposed society.<sup>8</sup> One week later the first medical society in the Oklahoma district was organized:

#### *MEDICAL ASSOCIATION.*

#### *ITS OBJECTS AND ITS OFFICERS.*

The physicians of the city met as per adjournment at Dr. Bradford's office at 8 p.m. last evening and perfected a permanent organization under the name of 'The Oklahoma Medical Society.' The officers are: L. W. Benepe, Pres., Delos Walker, Vice Pres., W. M. Baird, secy., H. C. Way, Treas.

The objects of the Society are shown in the preamble which is:

'We, the physicians of Oklahoma City, South Oklahoma and vicinity, for the purpose of investigating by discussions, lectures and essays, all that pertain to our profession — including our relations to our patients and to each other, do hereby organize ourselves into a Medical Society . . . .'

A Cordial invitation was extended to all physicians of whatever school of practice to meet and participate in all our discussions . . . .

Dr. L. W. Benepe, the President of the association, is a physician of extended practice and fine reputation both in Kansas and Illinois.<sup>9</sup>

The constitution and the qualifications for membership were not included, but brief biographical notes about the officers were printed in this article. The names of other doctors,



## Organization/HOWARD, et al

often with personal notes, are scattered through 1889 publications. One example from the July 18th and adjacent issues of the *Gazette* is the following advertisement:

Mrs. Dr. M. E. Prince, Physician. Special attention given to chronic and female diseases. Office on Reno avenue near Robinson.

The notices of some graduates included the MD designation while others used physician and surgeon, or doctor.

Despite the professed welcome to practitioners of every type, all the known members of the society claimed the MD degree. However, the medical education of several members is questionable, since no evidence of their graduation from medical school was provided in the 1890 or 1893 editions of Polk's *Register*.<sup>10</sup> Doctor H. B. Woods had no diploma acceptable for certification by the Oklahoma Territorial Board of Medical Examiners in 1891, but the doctor received the territorial license after passing an examination.<sup>11</sup>

Doctor L. W. Benepe had been closely associated in Kansas with Captain W. L. Couch, the famous Oklahoma Boomer and first mayor of Oklahoma [City]. Benepe's personal bravery in encounters with the fists and drawn weapons of the local bandits and his professional care of wounded victims frequently drew commendation in the *Gazette*. His social position and reputation as an experienced frontiersman may have been more influential in his election than professional ability. In the spring of 1890 Couch was shot near the kneejoint during a land claim dispute. Doctor Benepe dressed the wound without amputating the leg, and he predicted permanent stiffness at the knee. Complications unfortunately set in. Consultants were summoned and they deliberated amputation. However, the diagnosis of blood poisoning resulted in a verdict against surgical intervention at that time and death occurred within three weeks. The same month two other doctors performed immediate amputation at the shoulder for the victim of an accidental shotgun wound.<sup>12</sup> Benepe's reputed graduation from Bellevue Hospital Medical College should have satisfied medical examining boards, but he did not acquire a medical license in Oklahoma Territory between 1891 and 1896. He was listed in Polk's *Register* as practicing in Oklahoma City up to 1893, but

his name is absent from the 1896 edition.<sup>10, 13</sup>

By the spring of 1890 there had been several developments of importance to physicians, but no evidence has been found of meetings of the first Oklahoma Medical Society after its organization in June 1889. Since the society had an unrestricted membership, probably it could neither control the professional activities of the physicians nor influence the provisional governments. Presumably the regular physicians now felt the need for a stronger professional organization. Public health legislation had not been enacted in the territory prior to passage of the Organic Act on May 2, 1890. Furthermore, medical advertisements which were clearly unethical by the standards of the American Medical Association appeared frequently in lay publications. The following notice in the Oklahoma City Times was submitted by one of the organizers of the first medical society.

D. D. Halsted, M.D. 404 West Main St.  
Oculist Obstetrician & specialist. 25  
Years Professional Experience CURES  
CATARRH and all Eye Throat Sexual  
Venereal Chronic and Female Diseases,  
PILES, FISTULA, RUPTURE, HYDROCELES,  
FEVER SORES, DEFORMITIES, Etc. Guarantees safe conduct of  
all complicator[ed] and difficult Obstetrical cases. Solicits Severe, Critical and so  
called incurable cases. Consultation  
Free.<sup>14</sup>

A new Oklahoma Medical Society held an initial meeting in Oklahoma, Oklahoma Territory, on May 12, 1890, when officers and censors were elected, but detailed minutes have not survived. The first regular meeting was held on June 9th in the office of Doctor William R. Thompson. Also attending were the president, Doctor James R. McIlvain; secretary, Doctor Charles F. Waldron; Doctors Samuel Graham, Andrew J. Beale, Henry H. Black, and Claudius B. Bradford. The three-man Board of Censors was completed by the naming of Doctor James R. Ryan to replace a removed member. The bylaws are no longer extant, but the minutes clearly indicate that the Board of Censors required verification from a recognized college of regular medicine of the applicant's graduation, and adherence to the AMA Code of Ethics.<sup>5, 15</sup> The society accepted several graduates of inferior medical schools, such as the College of Physicians and Surgeons of Baltimore, and the Medical De-



partment, Arkansas Industrial University of Little Rock. The standards of medical education, however, were not as strict then as those established in the next decade.<sup>16, 17</sup> Several other men, such as Joseph B. Rolater, MD, Vanderbilt University 1884, graduated from schools which qualified them for election later to AMA affiliated associations, but they were not elected to the 1890-1893 society. The deliberations of the censors were not recorded but personal bias may account for these rejections. The contemporary medical association in Indian Territory, like many other affiliates of the AMA, required adherence to the Code of Ethics but the regulation of the Oklahoma Medical Society in 1890 was rigorous and formal. Membership was open only to applicants whom the censors deemed worthy to sign the following pledge:

We the undersigned regular practicing physicians of Oklahoma Territory hereby regard the Code of Ethics of the American Medical Association as our code and standard, with which association and through which we affiliate and derive our authority.<sup>5</sup>

Some physicians may have been justly excluded, while others probably regarded this requirement as a personal affront. Individual interpretations of ethical standards have varied widely despite the efforts of organized medicine to attain uniformity.

The minutes of the Oklahoma Medical Society reveal the wide range of interests of the member physicians through the topics chosen for presentation. On June 9, 1890, C. F. Waldron read the first paper, "The Effect of Modern Civilization on Longevity." The title raises intriguing questions regarding the attitude of these pioneers to urban industrialization and to their aspirations for the new city and territory.

Subsequent presentations covered many fields of practice, as shown in the following list: "Errors of Refraction," by W. R. Thompson; "Typhoid Fever," by C. B. Bradford; "Empyema," by Delos Walker; "Pneumonia," by H. H. Black; "Epidemic Catarrh," by W. H. Clutter; "The Plea of Insanity," by Waldron; "The Duties of the Doctor," by Walker; and "Intersitial Keratitis," by Thompson. Several papers were accepted for publication, eg those by Bradford and Clutter.<sup>18, 19</sup> Unfortunately, the minutes provide little comment about the presentations except an infrequent note indicat-

ing a lengthy discussion.

Interesting cases were reported at several meetings. Examples include "Hiccough accompanying pleuro-pneumonia," by Walker; "Hematemesis" by Thompson; "Puerperal eclampsia," by Walker; "Tuberculous ulceration of bowels," by Bradford; "Esophageal perforation after ingestion of a foreign body," by Thompson; and "Traumatic tetanus with recovery," by Walker. Such case reports often evoked comments and treatment recommendations. On other occasions the presiding officers talked about "State Medicine" and "Membership in the Society." Often discussion concerning the regulation of practice in the county and territory precluded the scheduled clinical reports.

The members repeatedly showed their concern about elevating the standards of practice and obtaining passage of public health legislation. On August 28, 1890, the first legislature in Oklahoma Territory convened at Guthrie. The minutes of the medical society September 1st state:

In view of the pressing needs for regulating the practice of medicine in this Territory, Drs. McIlvain, Waldron, and Bradford were elected as delegates from this Society to confer with the legislators at Guthrie and recommend to them the passing of an efficient bill to that effect at an early date.<sup>5</sup>

The *Gazette* on the following day reported that this committee would represent the "Oklahoma County Medical Association" in conference with the legislature. A letter in support of this action from an anonymous MD appeared in the October 28, 1890, issue of the *Gazette*. He directed the attention of the territorial legislators to the urgency of a good "medical and pharmacy law," and suggested the Illinois law as the best model. The chief benefit from such legislation would accrue to the public through the elimination of serious errors by health practitioners.

The Oklahoma Territorial Legislative Assembly passed an act, effective December 25, 1890, "creating a board of health and regulating the practice of medicine."<sup>11, 20</sup> The Territorial Superintendent of Public Instruction was ex-officio president of the Board of Health. The governor, with legislative approval, appointed the vice president and a superintendent of public health for two-year terms. The latter was required to be a territorial resident



and "graduate of some medical college recognized by the American Medical Association." The territorial board was responsible for appointing county boards of health, whose superintendents must hold a license to practice medicine. Medical licensure depended upon the approval of the Territorial Board of Medical Examiners, which consisted of the superintendent and two other physicians nominated by the Territorial Board of Health. For a two dollar fee a license would be awarded holders of diplomas of graduation from "a medical college," while other established practitioners of good moral character might satisfy the requirements by examination before this board. In 1891 the Republican governor appointed Doctor James A. Overstreet of Kingfisher to be the first Superintendent of Health. Joining him on the Board of Medical Examiners were Doctors Eugene O. Barker of Guthrie and Waldron of Oklahoma City. The first Board of Health of Oklahoma County consisted of Mr. J. A. J. Bauguess, president; Doctor W. H. Clutter, vice president, and Doctor J. R. McIlvain, County Superintendent of Health.<sup>11</sup> After the appointment of a Democratic governor in 1893, Doctor C. D. Arnold of El Reno became Superintendent of Health, and Doctor James A. Ryan of Oklahoma City was vice president of the Territorial Board of Health.<sup>21</sup> Of the office-holding physicians, Waldron, Clutter, McIlvain and Ryan were members of the Oklahoma Medical Society in 1890, while Overstreet joined soon thereafter.

The standardization of professional fees and problems of collections were recurrent concerns. The Oklahoma Medical Society membership, approximately 24 regular physicians, represented only a small part of the practitioners in Oklahoma County and a still smaller proportion of those in the Territory. On January 9, 1893, however, the society took the lead by creating a committee, whose stated purpose was "to perfect a Physicians' Alliance and to attempt to secure further legislation."<sup>25</sup> The committee consisted of two society members, J. R. McIlvain of the city and Anson A. Davis of El Reno, and a visiting non-member, Doctor Frank M. Hawley of Oklahoma City. The *Gazette*, January 25th and February 22nd, 1893, reported the formation of "The Physicians' Protective Union." The January 25th account read:

The physicians and surgeons of Oklahoma City and vicinity met in Dr. McIlvain's office last night and formed an association ostensibly to protect themselves from the invasion of quacks and nomadic members of the medical fraternity but in reality to establish a uniform basis of fees for individual attendance. Dr. McIlvain was elected President; F. S. Dewey, Vice President; Dr. Black, Treasurer, and Dr. F. M. Hawley, Secretary.

. . .

The subsequent news report indicated that only 15 doctors attended the meeting on February 21st. However, every licensed physician in the county was given the privilege of inspecting the list of non-paying patients kept by the Protective Union secretary. Three officers of the union were members of the Oklahoma Medical Society. The secretary, a graduate of the Iowa Medical College [eclectic] of Drake University, Des Moines, was ineligible for society membership, even though he affirmed adherence to the regular method of practice.<sup>10, 11</sup> Hawley's selection was probably expedient to gain the cooperation of the greatest number of practitioners.

The members of the Oklahoma Medical Society apparently considered it to be a local rather than a territorial body, but several men were elected from points outside Oklahoma County. One of the founders, Doctor W. R. Thompson, attended meetings of the Indian Territory Medical Association (ITMA) regularly after October 10th, 1889, and held the posts of secretary and president from 1890-1892. The ITMA adhered to AMA regulations and the Code of Ethics, thus providing a model for the Oklahoma Medical Society, <sup>4</sup>(pp. 149-152),<sup>22</sup> Probably the members hoped to influence the formation of a larger organization in Oklahoma Territory. Indeed, the minutes for October 20th and November 1st, 1890, refer to a planned meeting of the "Territorial Association" on November 3rd, and a notice to that effect appeared in the *Gazette* of November 1st. The society minutes subsequently indicate that a territorial association meeting was tentatively scheduled for May 4, 1891, but there is no evidence that these meetings actually took place.

The successful launching of the Oklahoma Territorial Medical Association in 1893 is usually attributed to the editorial by Doctor Eugene O. Barker of Guthrie in the March



1893 issue of the *Oklahoma Medical Journal*. Barker's service on the Territorial Board of Medical Examiners in 1891-1892 with Waldron and Overstreet, both members of the Oklahoma Medical Society, undoubtedly made him cognizant of the society, but he apparently considered it only of countywide significance.<sup>23</sup> The minutes of this society close with the report for March 6, 1893, although an April meeting was scheduled. Thirty-four physicians met on May 9th, 1893, at the Grand Avenue Hotel in Oklahoma City to discuss the formation of a territorial association which a large majority approved. Twelve members of the Oklahoma Medical Society, including McIlvain, Black, Bradford, Clutter, Thompson, Ryan, Overstreet and Delos Walker, were among the 28 charter members of the territorial association. <sup>4</sup>(p. 153),<sup>23</sup>

Six men served as presidents of the Oklahoma Medical Society from May 1890 through March 1893, as new officers were elected semi-annually. The number of meetings held under each presiding officer may reflect his leadership, as well as the general interest of the membership in medical organization at that time. Doctor James R. McIlvain presided at the first seven meetings up to November 1, 1890. Organization of the society itself and territorial medical legislation preempted the meetings. Only one formal paper was presented and one group of cases discussed. Doctor McIlvain was scheduled several times but never read a professional paper during the existence of this society. Born in Kentucky in 1851, he was graduated from the Kansas City Medical College, Missouri, in March 1882, and married the sister of Doctor C. B. Bradford. While located near Council Grove, Kansas, McIlvain served as surgeon to the Missouri Pacific Railroad. He moved to Oklahoma City in September 1889, and practiced independently until he formed a partnership with Bradford in September, 1890. He specialized as an anesthesiologist for several years before his death in Oklahoma City on November 26th, 1903.<sup>24</sup> (Fig 1)

Doctor Charles Finlay Waldron, the first secretary of the Oklahoma Medical Society, was elected president in November 1890. At each of the five meetings professional papers were read, and several were submitted for publication. Waldron presented three topics during 1890-1891. After completing his term as president, he served on the Board of Censors and attended meetings regularly until the fall of



Fig 1 Dr. J. R. McIlvain

1892. Born in New York in 1844, Waldron graduated in 1874 from the Medical Department of the State University of Iowa, Iowa City. He practiced in Oklahoma City from 1889 and had a homestead in Liberty Township, northwest Cleveland County, but soon relinquished it.<sup>10, 11, 26, 27</sup> Waldron was active in Masonic affairs and in the Republican Party.<sup>28</sup> These contacts may have facilitated his appointments as member of the US Board of Pension Examiners at Oklahoma City in January 1890, as vice president of the Territorial Board of Health and as treasurer of the Board of Medical Examiners in April, 1891. The territorial positions appear prestigious, but paid only small sums to cover actual expenses.<sup>11, 29</sup>

Although prominent among the first medical administrators in the new territory, Waldron's career suddenly changed. News items in the *Oklahoma Daily Times-Journal* on October 1st and 2nd, 1892, do not clarify whether he was removed or resigned from the US Pension Board, but soon thereafter he left the state to



attend graduate courses in New York.<sup>30, 31</sup> His name was last entered in Polk's *Register* in 1896, the year after he enrolled as a seminary student at the Catholic University in Washington, D.C. He served as an ordained priest from that time until his death on October 19th, 1915, when pastor of Immaculate Conception Church in Maloy, Iowa.<sup>10, 32</sup> During his early vocation as physician, Charles Waldron contributed greatly to medical organization in Oklahoma Territory.

Doctor Claudius B. Bradford, a charter member and the second secretary, was then elected president of the Oklahoma Medical Society. He served from May to November 1891, with Doctor Delos Walker as secretary. Only three meetings took place, but the minutes contain detailed clinical discussions. Bradford served two terms on the board of censors, and was again elected secretary in December, 1892. In all, he made three clinical presentations, which his colleagues considered of superior quality. A later publication on typhoid fever included a review of the current American literature and demonstrated good clinical judgment.<sup>18, 33</sup>

A graduate of the Kansas City Medical College in 1882, Bradford moved from Kansas to Oklahoma City in May 1889, during his 34th year.<sup>11, 26</sup> Throughout his career he was an active practitioner and citizen. He was one of the prime movers in the founding of three successive associations to elevate professional standards: the first Oklahoma Medical Society in June 1889, the succeeding society in May 1890, and the Territorial Medical Association in May 1893. He was the president of the latter body in 1899-1900, and continued practice in Oklahoma City until 1921.<sup>4(p. 56), 25, 34</sup> It is regrettable that his contributions to Oklahoma medicine were not rewarded by an honorary membership in the Oklahoma State Medical Association. (Fig 2)

The half-year terms of the three subsequent presidents were less eventful in the history of the 1890-1893 medical society. Henry H. Black, (MD 1878, Indiana Medical College), Delos Walker (MD 1864, University of Michigan), and William H. Clutter (MD 1868, Cincinnati College of Medicine and Surgery), each arrived in Oklahoma during 1889, and were charter members of the Oklahoma Medical Society in 1890 and the Territorial Medical



Fig 2 Dr. Claudius B. Bradford

Association in 1893.<sup>10, 11, 23</sup> Black served on the local Board of US Pensions from its initiation until 1895, when his home was sold, and he apparently died shortly thereafter.<sup>29, 35, 36, 37</sup> Clutter, born in 1832 in Kentucky, managed a homestead in Oklahoma County in 1889 and a medical practice in Oklahoma City from that year through 1909.<sup>25, 27, 34, 38</sup>

Doctor Delos Walker was conspicuous in the prohibition cause, politics, and civic affairs.<sup>4, 6, 39</sup> He was the first president of the Oklahoma City school board. Walker rivaled Bradford in stimulating the organization of the successive medical societies in Oklahoma from 1889 through 1893. Possibly in part due to his 56 years and thus seniority among physicians in the new territory, Walker was elected the first president of the OTMA in 1893.<sup>4, 23</sup> (Fig 3) Comparison with illustrations in other publications indicates that his portrait in the May 1956 issue of the *JOSMA* was erroneously interchanged with that of Doctor T. A. Cravens.<sup>4(p. 155), 25, 38, 39</sup> The intense expression about the eyes and face of the portraits of Doctors Walker and Bradford may reflect simi-



lar habits of concentration on affairs of social organization.<sup>4</sup>(p 156)

The years 1889-1893 were within a period of rapid change in American medicine. Graduate and non-graduate practitioners were so numerous that those with inferior training often moved to the less settled regions including the unorganized territories. Prior to the opening of Johns Hopkins University School of Medicine, the European scientific discoveries in bacteriology, pathology and chemistry had not influenced many established practitioners or even the majority of the teachers in the North American Medical institutions. The American Medical Association for decades fought against the sectarians without the general support of the regular medical profession. Improvements in standards of medical education and practice would follow within 20 years.<sup>16, 17, 40</sup>

In the early 1890's the quality of professional medical practice in urban centers such as St. Louis and Kansas City was probably better than in the remote farming communities of Missouri or other states near Oklahoma. Living conditions in the new territory were turbulent and difficult. Yet it appears creditable that public health legislation in the territory had been enacted and the medical profession organized according to the contemporary national standards within four years of the opening to pioneer settlement.

The short life of the first medical society of June 1889 may have resulted from difficulties in obtaining consistent cooperation between practitioners of widely different training and socioeconomic aims in the pioneer town. No direct link is apparent between the 1889 organization and the small group of regular physicians who founded the Oklahoma Medical Society at the vigorous commercial center in 1890. The thoughtful proposals of this group of physicians influenced territorial legislation. Political rivalry between Guthrie and Oklahoma City and difficulties in transportation are the apparent reasons that their society remained principally at the local level. By 1893 the rapid growth of population and the increased railroad network made it timely to launch a territorial organization. For several years after May 1893 no county medical society was active in the Oklahoma City area. The energetic leaders of the Oklahoma Medical Society from Oklahoma City and other towns shared with new men in the formation of the



Fig 3 Dr. Delos Walker

Oklahoma Territory Medical Association. This association through its successor, the Oklahoma State Medical Association, still thrives.

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73190

## OKLAHOMA SURGICAL ASSOCIATION MEETING

**Fountainhead Lodge, March 22nd, 23rd, 24th, 1974**

All members and other interested physicians are urged to attend this three-day assembly of the Oklahoma Surgical Association to be held at Fountainhead Lodge on Lake Eufaula, March 22nd, 23rd and 24th, 1974.

Two outstanding guest speakers have been named for the meeting. They are United States Senator Henry Bellmon, and Thomas Morse, MD, Chairman of the Pediatric Surgical Outpatient Department of the University of Ohio. The Senator's presentation will be an adjunct to the general scientific program which will emphasize traumatic diagnosis and treatment.

Entertainment has been planned for wives of attending physicians.

Further information regarding reservations and pre-registration may be obtained from the Program Chairman, E. W. Jenkins, MD., 6465 South Yale, Suite 804, Tulsa, Oklahoma 74136, telephone 622-4622. ☐



# FDA And The Physician: The Dialogue Deepens

ROBERT L. DEAN

*FDA is beginning to listen to the private practitioner. To be heard, though, the practitioner had better prepare himself and get involved with FDA's new advisory committees.*

I appreciate this opportunity to talk to you.

I plan to make just one point: I think FDA is listening—and listening attentively—to what you physicians have to say. It's certainly not news that FDA, nowadays, has to do a great deal of listening. It listens to Congress; it listens to scientists; it listens to consumerists. Once in a while, it even listens to what we in industry have to say.

And more and more, it is listening to what private practitioners have to say — the good and the bad—about drugs. Some of you are already talking to FDA, and talking effectively.

It's probably fair to say that, for a good many years, most physicians have taken FDA for granted as the agency somehow responsible for assuring the quality of drugs, and the fairness of drug advertising. They have given FDA credit for that, glad that someone was there to do the job.

But they have not taken so kindly to the fact

that FDA is also interested in assuring the quality of the physician's *use* of drugs. You'll recall FDA's concern, back in 1967, with a certain medical text that recommended a drug dosage exceeding the dosage in the package insert? One vocal physician got very exercised over FDA's attempt to invest the insert with unnatural powers over prescribing, and FDA listened.

But that was just a minor skirmish, compared to what lies ahead. Over the past five or six years, FDA and others have been saying that the use of many prescription drugs by physicians far outweighs genuine need. It's been said repeatedly that physicians overuse drugs, are overwhelmed by their number and variety, are not as concerned as they should be about drug toxicity and drug interactions.

What do physicians think of these serious criticisms? What do you say about them? To whom do you say it?

And will anybody *listen* to what you have to say?

In order to communicate effectively with FDA, the physician first must decide that he has something important to say. He has to believe he *knows* what he *knows*. He must believe his practical experience with drugs *does* count for something. Then he must do something with what he knows. As the ancient satirist poet Lucilius put it: "Knowledge is not knowledge until someone else knows that one knows."

This does *not* mean he should derogate the modern methodology of drug research, nor poke fun at double-blind placebo controlled studies, nor at the academicians who advise FDA. With-

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Presented before the meeting of state medical association presidents on "Federal and State Legislative and Regulatory Issues Affecting Medicine," December 1st, 1973, in Anaheim, California.



## FDA/DEAN

out these modern techniques and expert advisors, the FDA judgments of safety and efficacy would be paralyzed, or hopelessly wrong. And to say otherwise marks the sayer as an anti-intellectual.

To communicate effectively, private practitioners must find a way to help FDA appreciate and value their clinical experience with drugs. During the past decade—and especially during the past three years—FDA has seemed to reject evidence not obtained from double-blind, statistically controlled studies. Yet—and here's an important paradox—FDA is increasingly looking to advisory committees to help make its scientific decisions. So there is more to scientific decision-making than simple data. There is room, officially, for judgment and experience.

You can understand FDA's viewpoint on the need for data—the complex issue of approval of new drugs cannot be resolved without well planned, well controlled studies *before* the drug product is made available. It's FDA's clear intent and responsibility to make the best judgment possible at the drug's point of entry; once the drug is in your hands, they have lost direct control of its use. And I think it's fair to say that better control of drug use—to avoid overuse, abuse, and drug interactions—is what FDA wants.

Yet we and you—and FDA—appreciate that clinical experience *after* marketing is actually likely to be a better measure of the new drug's safety and efficacy than all the controlled studies. Experience measures all the subtle but vital effects a drug may have on the patient's performance, convenience, happiness.

Before a new drug is marketed, the sponsoring company collects the so-called "hard" data—the laboratory evidence, the quantitative and semi-quantitative measures of clinical improvement or cure.

After it's marketed, the practicing physician collects most of the soft data on the "patient's capacity for working, walking, dancing, making love, thinking, reading, and enjoying the other acts of daily living."

I borrowed that last phrase from a paper by Dr. Alvan R. Feinstein, now at Yale ("The Need for Humanized Science In Evaluating Medication," *The Lancet*, August 26, 1972, pp 421-23).

But how can the practicing physician communicate these subtle things to a federal

agency which, like the rest of us, is far more comfortable with quantitative measures of effectiveness? We all know that unsupported and isolated testimonial clinical evidence isn't enough. We also know that there are kinds of important knowledge that are beyond capturing by double-blind placebo controlled study.

Is there anything in between? Any place where clinical experience can be organized to get the attention it deserves? I think so; and I have a few examples to share with you.

The first example involves FDA's handling of prescription cough and allergy combination products. On June 4, 1973, FDA held an all-day public hearing on its guidelines for the formulation of cough and allergy products. It had published these guidelines in the *Federal Register* of May 15, just two weeks earlier. The guidelines were designed to show how new products could be formulated as substitutes for all of the combinations FDA had declared "ineffective"—among them such widely prescribed products as Phenergan, Actifed, Benylin, 'Tuss-Ornade.' The *Federal Register* is the FDA's way of communicating with "all interested parties," including the physician. The FDA has many other ways of communicating—in the speeches of its personnel, in frequent testimony before Congressional committees, in hundreds of letters to drug companies.

As a matter of fact, the FDA's half of the dialogue with physicians is voluminous; I sometimes think that *words*, not drugs, are the principal business of both FDA and the industry.

We in the industry have learned to read the *Federal Register* in a hurry, quickly separating the boilerplate paragraphs from the substance.

Fortunately, some few physicians are just as good at speed-reading the *Federal Register*. With only a five-day deadline, several asked for and were given time to testify at FDA's public hearing on the cough-allergy guidelines.

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*Robert L. Dean is Vice-President of Regulatory and Government Affairs in the US Pharmaceuticals Division of Smith Kline & French Laboratories, Division of SmithKline Corporation. Mr. Dean is a graduate of La Salle College, a member of the American Medical Writers Association, the National Association of Science Writers, and the American Association for the Advancement of Science. He is the author of many articles on medical writing.*



The physicians who testified were concerned about the loss of useful, time-tested products. But I think they were much more concerned about the erosion of their prescribing choices and the failure of FDA to take their experience into account.

Doctor William Barclay of the AMA said it this way:

"It seems to me the only people who can tell you whether these mixtures have any effect on symptoms are the doctors in practice who are seeing people in their offices, dispensing the medicine, and then getting some reaction from the patients. So I would make the very, very strong appeal to FDA to put great weight on the evidence submitted by physicians who are qualified to judge whether or not the symptoms have been relieved."

Much the same point was made by three physicians in private practice, and by physicians representing the Congress of County Medical Societies and the American Academy of Family Physicians.

What happened as a result of the hearing?

FDA listened. It decided to postpone implementation of the prescription cough-allergy guidelines. It deferred action until its panel that is reviewing *non*-prescription cough-cold-allergy products can complete its job, which will probably be at the end of 1974. As you probably know, FDA has divided the non-prescription (OTC) drugs into 17 categories, and 17 panels will review them.

Is the cough-cold-allergy argument over? Hardly; it's only suspended. Keep in mind, FDA's OTC panel must now wrestle with the very same questions FDA has published answers to. Are antihistamines of any use in the symptomatic relief of colds? Should combinations of antitussives and decongestants be allowed?

And here's the \$64 question: shouldn't *all* cough-cold-allergy products be *non*-prescription anyway? FDA asked this question several times at the June 4th hearing. One physician answered that he could only deplore the suggestion. It would leave physicians with nothing to prescribe for the patient whose symptoms are severe enough to have brought him to the physician.

At the close of the June 4 hearing, FDA's Doctor Richard Crout, who conducted the hearing, said to AMA's Dr. John Budd, "We make a strong plea to you to help us solve the problem."

He did not mean just the problem of whether one drug product goes and another stays. Let's face it, what eventually happens to Phenergan or 'Tuss-Ornade' is important only as part of the overall problem of how you can contribute to the judgments being made about drugs in this country.

Doctor Francis Davis, who is the publisher of *Private Practice*, the official publication of the Congress of County Medical Societies, has visited FDA with the officers of his society. They have talked to FDA about the need to increase the dialogue with private practitioners. FDA has encouraged Dr. Davis and his colleagues to find ways to collect and translate clinical experience that bears on judgments of safety and efficacy.

As a start, *Private Practice* published a self-mailing questionnaire in its September issue. The questionnaire tells physicians that FDA has classified 480 drugs as "possibly effective," and that FDA must make a decision on them by January, 1974, unless it can be shown that they are effective or that the medical issues are so complex that more time is needed. The questionnaire then selects 25 of the 480 and asks whether the reader has found them effective.

Obviously, this questionnaire is but a first step; perhaps its greatest worth is in stirring physicians to make formal judgments of clinical efficacy; it can be the beginning of the development of teams of practitioners willing to record and thus document their experiences with drugs, including adverse reaction experience, patient-by-patient, in a way that can give validity to what would otherwise be isolated observations, confusing and meaningless in a regulatory sense.

A third example of a way physicians have found to try to understand what they know, to organize it, and then to communicate it: just yesterday in Washington, the Academies of Family Physicians of Virginia, Maryland, and the District of Columbia concluded a two-day conference on combination drugs—the science of them, the merits and demerits of them. There has been so much said about combination products, much of it fruitless. Perhaps this conference will help physicians see the issues more clearly, and thereby help FDA.

A fourth example of FDA's ability to listen occurred this past summer when FDA acknowledged in the *Federal Register* of August 8, 1973, that it had received "numerous complaints from physicians, including eminent



gastroenterologists, objecting to removal . . . [of the poorly absorbed sulfonamides, *eg*, succinylsulfathiazole, phthalylsulfathiazole]" from the market. The Commissioner rescinded the order to withdraw these drugs. An editorial in the October 15, 1973, JAMA hailed this action as "evidence that reasonableness can prevail."

A fifth and final example of FDA's interest in the opinions of others is provided by the agency's vastly increased use of advisory committees. At last count, there were some 27 standing committees—you name it—on dental drug products, bacterial vaccines, orthopedic devices, topical analgesics, etc.

I doubt that a day goes by at FDA without a meeting of outside advisors.

Notification of the time and place of these meetings is published in the *Federal Register*. Most are closed to us and the public except for perhaps an hour or two, but even that brief period has been enough to show us that these committees are by no means rubber stamp. They have their problems—what committee doesn't? They work hard at the job, they take seriously the fact that they're helping FDA with tough decisions. And it's been clear they expect FDA to take their advice seriously.

One of the committees' problems is their natural desire to make difficult decisions on as much data as can be found, and to call for more if not enough is around. They tend to forget that if the data were complete, there'd be little need for advisory committees. The best committees seem to be those that demand data when it's critical and when the methodologies for getting it are available, but that, otherwise, rely on their judgments of safety and efficacy.

How well are primary care physicians — that is, private practitioners — represented on these committees? On some of them there may be no great point. But on others, there *is* a great need for them to be heard. As the new Commissioner, Doctor Alexander Schmidt, put it at a press conference July 26:

"I think we may be a little shy in representation from the MD practicing world on our committees. One can argue whether a practicing MD is a 'professional' or a 'consumer.' In a way, the MD is a consumer of our regulations. He needs to be heard."

So I hope I've established that FDA does listen.

But that doesn't mean FDA—or at least some of the people there, and in HEW—are not still very much concerned over what I mentioned earlier. They are concerned that many physicians are overprescribing tranquilizers, and antibiotics, are prescribing fixed-ratio combinations without enough thought being given to titrating doses and ingredients to suit the individual patient. They are worried about the drug interactions that can result, and about the giving of ingredients that are simply not needed. They believe that the industry's heavy advertising and promotion has oversold drug products and made physicians thoughtless in prescribing. They are determined to find out just how much overprescribing is going on.

To the extent FDA is right about any of this, the industry and the medical profession had best be busy correcting itself. To the extent FDA is wrong, we'd best be telling them so, in the most cogent way we know. In any case, surely the private practitioner will want an effective voice in the decisions likely to be made about drug consumption in the next decade.

I've mentioned several ways of increasing dialogue with FDA. The first and best is by data, brought to their attention through the literature and through symposia. I've mentioned visits to FDA, surveys of clinical use and experience, testimony at public hearings.

And I've tried to stress serving on FDA advisory committees. The FDA is about to divide its work on drugs into 18 categories — cardiovascular-renal drugs, dermatological-surgical products, psychopharmaceuticals, antibiotics, etc; for each category there will be an advisory committee. I believe there is an opportunity and a need for the private practitioner on each of these committees, *not* as a replacement for the substantial scientific evidence that is needed for the clearance of new drugs, but rather for the help such physicians can give in making judgments about such things as comparative toxicity, relative efficacy of new vs older agents, actual or likely modes of use.

On both new and old drugs there will be questions the private practitioner can and *should* help with. For example: How shall the indications section of the labeling be worded so that it cannot be misread? What should be done about labeling for the *patient*? How can such-and-such an adverse reaction be best communicated to the physician? Should this new drug be made available only for hospital or other restricted



use? Should this old drug be made non-prescription? How can post-marketing surveillance in actual use best be done?

\* \* \*

There is still another way for physicians to communicate, one I'd like to illustrate with a true story about dialogue with government.

A friend of mine named Ed has a friend who's a member of an important Congressional Committee. Ed has another friend who's a physician and who attends the same church the Congressman attends, and knows him quite well. One day, Ed asked the physician what he talked to the Congressman about when they met in the Church parking lot. "Oh, school, church, weather."

Ed suggested there *are* other topics — including large medical topics that are very important, and the physician agreed.

Later, Ed saw the Congressman and confirmed that all he and his physician friend ever talked about was school, children, and so on, and Ed gave the Congressman his business card, with this request. "Look," Ed said, "I've urged Dr. so-and-so to bring up something besides the weather and I've told him I'm sure you'd be interested in his opinion on national medical issues. Let me know what happens when you next talk to him; send me a note on my card."

A few weeks ago, Ed's card arrived back in the mail. It had just two words written on it: "He didn't." □

Smith, Kline & French Laboratories, Philadelphia, Pennsylvania 19101



# OKLAHOMA MEDICAL SUMMIT

## A Combined Meeting of

The Oklahoma State Medical Association

The Oklahoma City Clinical Society

The Oklahoma Academy of Family Physicians

May 12-15, 1974

**AT THE MYRIAD**

Oklahoma City, Oklahoma





## News From The Oklahoma State Department of Health

### BOTULISM

There is little doubt that botulism is more common than reported. There is a full spectrum of illness, ranging from mild neurological disturbances that escape detection, to rapidly fatal disease. The fully developed clinical syndrome in a group of people having ingested a common meal is easily recognized. The isolated or atypical case may be extremely difficult.

The symptom complex of fatigue, and visual disturbances such as diplopia, blurred vision, blepharoptosis, and diminished pupillary light reflex, strongly suggest botulism. Dysphonia, dysphagia and other signs suggesting bulbar paresis usually follow visual disturbances. Difficulty in breathing results from respiratory muscle involvement. Dryness of the mouth and

extraocular palsies are also commonly observed.

There are no sensory disturbances and the patient's sensorium remains clear usually until the onset of terminal complications. There is characteristically no elevation in body temperature in uncomplicated botulism. Superficial and deep tendon reflexes remain intact, and routine blood, urine, and cerebrospinal fluid studies remain normal.

Gastrointestinal symptoms do not usually occur in botulism, but may indicate concurrently ingested spoiled food, or type E botulism (most commonly associated with unsatisfactorily canned fish).

Respiratory paralysis, airway obstruction and/or secondary infection are the major causes of death in botulism.

Treatment consists of early respiratory assistance (tracheostomy and respirator), cleansing enemas, and trivalent A, B, E botulinus antitoxin (in persons negative in serum sensitivity).

For information concerning botulinus antitoxin, call 405—271-4060, collect. □

### COMMUNICABLE DISEASES IN OKLAHOMA FOR DECEMBER, 1973

DISEASE	December 1973	December 1972	November 1973	Total To Date	
				1973	1972
Amebiasis	2	2	1	31	29
Brucellosis	1	—	—	6	8
Chickenpox	14	6	15	1348	168
Encephalitis, Infectious	—	2	3	101	20
Gonorrhea					
(Use Form ODH-228)	926	946	654	10636	10003
Hepatitis, A, B, Unspecified	87	71	64	1140	895
Leptospirosis	—	—	—	—	2
Malaria	—	—	—	3	6
Meningococcal Infections	3	6	1	37	15
Meningitis, Aseptic	4	2	2	107	72
Mumps	44	2	10	512	166
Rabies in Animals	13	13	5	168	291
Rheumatic Fever	—	1	2	16	28
Rocky Mountain Spotted Fever	1	—	—	77	39
Rubella	4	2	1	186	45
Rubella, Congenital Syndrome	—	—	—	—	—
Rubeola	1	2	5	62	12
Salmonellosis	28	22	15	290	169
Shigellosis	18	44	9	204	259
Syphilis, Infectious					
(Use Form ODH-228)	20	10	11	174	119
Tetanus	—	—	—	4	1
Tuberculosis, New active	30	28	28	337	328
Tularemia	—	2	1	23	13
Typhoid Fever	—	—	—	2	3
Whooping Cough	2	1	—	23	36



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## Oklahoma Medical Summit: A Progress Report

The four-day Oklahoma Medical Summit meeting promises to be the "biggest and best" medical meeting ever to be held in Oklahoma. Jointly sponsored by the Oklahoma Academy of Family Physicians, the Oklahoma City Clinical Society, and the OSMA, the meeting is scheduled for mid-May in Oklahoma City.

The beautiful new Myriad Convention Center will host the combined meetings of the three organizations with the Skirvin Plaza Hotel serving as convention headquarters. The first day of the meeting, Sunday, May 12th, will be given over to official business meetings of the organizations, while the scientific program will start on Monday morning, May 13th, and extend through Wednesday afternoon, May 15th.

### Scientific Program

The scientific program of interest to physicians will begin at 8:15 a.m. on Monday morning with a film entitled "Acupuncture Anesthesia for Surgical Operations" in the Myriad. This will be followed by an all morning special scientific session on acupuncture by two of the nation's authorities on the subject Yiu Wing Choi, MD, and Richard Kroening, MD. Their topics will be "Modern Acupuncture and the Western Medicine" and "Acupuncture in Perspective with Emphasis on Rheumatic Disease and Complications of Acupuncture."

Two scientific programs will be offered concurrently in the afternoon.

One of them revolves around psychiatry with a nationally known speaker, Beverly Mead, MD. Doctor Mead's two subjects will be "The Sexual Dilemma" and "Problems of the Adolescent." A panel of Oklahoma physicians, in conjunction with Doctor Mead, will discuss "How To Mend Your Old Cocks."

The second program for the afternoon will be on the subject of cervical cancer and will be sponsored by the Oklahoma State Unit of the American Cancer Society.

Tuesday morning's scientific program will start with a film and a demonstration. The film will be on obstetrics and gynecology at 8:15 a.m. At the same time a demonstration in cardiac resuscitation, "Are You Prepared To Start This Heart," will be conducted by Robert M. Smith, MD.

Three options are available on Tuesday morning for physicians attending Oklahoma Medical Summit.

One will deal extensively with problems in obstetrics and gynecology. Such topics as "Sexual Problems," "Anemia in Obstetric and Gynecologic Practice," "Abnormal Pap Smears" and "Management of Toxemia of Pregnancy" will round out the program.

The second option will be a seminar in diabetes. "Diagnosis of Early Adult Onset Diabetes" and "Newer Concepts and the Treatment of Diabetes" will be the two topics discussed in full.

"The Dizzy Patient" will be the subject of the third seminar available on Tuesday morning.

Two concurrent programs will be available Tuesday afternoon. Each will start at 1:45 and last until 5:00 p.m.

A companion to Monday afternoon's cancer program will be conducted Tuesday afternoon by the Oklahoma County Unit of the Cancer Society.

A seminar on endocrinology will round out the scientific programs available on Tuesday. "General Office Endocrinology and Diagnosis" and "OB-GYN Endocrinology" will be two of the subjects covered in-depth.

A film on "Renal Dialysis" will start Wednesday morning's scientific programs at 8:15 a.m.

At 9:00 a.m. three concurrent section meetings will get underway. One of the meetings will be on ophthalmology and otolaryngology, and another will concentrate on nephrology. A special seminar on "Current Diagnosis and Treatment of Venereal Disease" will be con-



ducted by the Oklahoma State Department of Health.

The ophthalmology and otolaryngology section will continue over into the afternoon on Wednesday and continue until 5:00 p.m.

#### Socioeconomic Program

During the three-day meeting there will be at least four presentations on socioeconomic subjects of interest to all physicians.

At 12:15 p.m. on Monday during a special luncheon, the guest speaker will be Russell Roth, MD, President of the American Medical Association.

The guest speaker for the luncheon Tuesday will be Harry Schwartz, PhD, Associate Editor of the New York Times and author of the book "The Case for American Medicine."

Wednesday's luncheon speaker will be James Price, MD, President of the American Academy of Family Physicians.

The final socioeconomic program during Oklahoma Medical Summit will take place Wednesday afternoon at 1:15 p.m. The subject will be Professional Standards Review Organizations, PSROs. Guest speaker will be Robert Hunter, MD, a member of the AMA's Board of Trustees and the AMA's representative on the national PSR Council.

#### Social Program

Entertainment is also a big part of Oklahoma Medical Summit. The first social function during the four-day meeting will take place Sunday evening, May 12th. The entire Gaslight Theatre in Oklahoma City has been reserved on that evening for physicians and their wives. Cocktails, dinner and a delightful theatre presentation will round out the evening.

Monday evening's festivities will revolve around a "Keg and Oyster Party" in the Myriad. Physicians and medical students will be invited to partake of the oceanic delicacies and wash them down with a fermented brew.

The social highlight of the year will take place Tuesday evening, May 14th, in Oklahoma City's beautiful Petroleum Club, atop the Liberty National Bank Building. A gourmet meal with appropriate wines will set off a "very brief" inaugural ceremony for the incoming presidents of the three sponsoring organizations for Oklahoma Medical Summit: the Oklahoma Academy of Family Physicians, the

Oklahoma City Clinical Society and the OSMA.

Highlight of the evening will be entertainment by Mr. Mark Russell, internationally known political satirist. Russell's songs and sayings about political happenings have made him one of the most "in demand" entertainers of today. While he seldom leaves the Washington, D.C. area, he usually plays to a full house sprinkled with Congressmen, bureaucrats, diplomats, cabinet members, national newsmen and socialites.

#### Business Program

Since this is the joint annual meeting of the three sponsoring organizations, there will be a number of business sessions conducted during Oklahoma Medical Summit.

The OSMA Board of Trustees will have its annual board meeting on Sunday morning, May 12th in the Skirvin Plaza Hotel.

At noon on Sunday the OSMA Board will join with the Oklahoma Academy of Family Physicians' Board of Directors for a luncheon in the hotel. The Academy's Board of Directors will meet at 1:00 p.m. that afternoon.

The opening session of the OSMA House of Delegates will convene at 3:00 p.m. on Sunday afternoon in the Skirvin Hotel's Convention Center.

The various reports from OSMA officers, councils and committees will be referred to four reference committees for public hearings starting at 7:30 a.m. on Monday morning in the Myriad. Following the meetings each reference committee will then prepare a final report to be submitted to the closing session of the OSMA House of Delegates at 2:30 p.m. on Wednesday afternoon, May 15th in the Myriad.

Nomination for new officers for the OSMA will take place at the opening session of the House on Sunday, with final election on Wednesday afternoon.

The annual membership breakfast and membership business meeting of the Oklahoma Academy of Family Physicians will take place Tuesday morning, May 14th in the Skirvin Plaza Hotel. Breakfast will be served at 7:00 a.m. for all members with a business meeting to convene at 8:15 a.m.

The Past-Presidents of the three sponsoring organizations will have their traditional breakfasts during the meeting. The Past-Presi-



dents of the OAFP will meet at 7:00 a.m. on Monday morning, the Oklahoma City Clinical Society Past-Presidents will breakfast at 7:00 a.m. on Tuesday morning, and the OSMA's Past-Presidents will breakfast Wednesday morning, all in the Skirvin Plaza Hotel.

#### Allied Health Programs

Twenty allied health organizations will conduct some type of scientific program or business meeting for their members in conjunction with Oklahoma Medical Summit. While most of the programs will take the form of half-day meetings for 50 to 60 members of the organization, some of the programs will be one and two days in length for up to 700 people.

As an example, the nurses' association of the American College of Obstetricians and Gynecologists anticipate 650 to 700 RNs will attend their scientific program during Summit.

Meetings will also be conducted by the Oklahoma Urological Society, District Branch of the American Psychiatric Association, Society of Cytopathology, Association of Operating Room Technicians, Association of Operating

Room Nurses, Oklahoma State Nurses Association, Oklahoma LPN Association, Occupational Therapy Association, Medical Records Association, Dietetic Association, Association of Nurse Anesthetists, the Oklahoma University Physicians Associate Program, the Oklahoma Chapter of the American College of Radiology and the Oklahoma City Clinic Managers Association. □

#### Stewart Wolf Lecture Planned

The annual Stewart Wolf Lecture will be presented at 4:00 p.m., February 27th, in the Basic Sciences Building of the University of Oklahoma Health Sciences Center.

Guest speaker for this year's program will be William D. Willis, MD, PhD, Chief, Comparative Marine Neurobiology, The Marine Biomedical Institute, Galveston, Texas. His topic will be "The Role of the Primate Spinothalamic Tract in Pain Transmission."

The public is invited to this lecture which is sponsored by the Stewart Wolf Society, a society of former interns, residents and students of Doctor Wolf. A reception, honoring Doctor Willis and Doctor Wolf will be held at the Faculty House following the lecture. □

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## PSRO Pot Continues To Boil

An early December action by the AMA's House of Delegates combined with the release of Professional Standards Review areas by HEW continue to keep the PSRO controversy boiling nationwide. To add to the confusion, proposed rules governing pre-certification and review procedures applicable to Medicare and Medicaid were published by HEW citing statutory authority other than PSRO.

Under the new proposed regulations, published January 9th, state Medicaid plans would be required to adopt a utilization review system, including among other requirements, pre-admission approval for elective institutional admissions. Many medical leaders viewed these new regulations as an attempt by HEW to pre-opt the prerogatives of the various PSRO sponsoring groups and force them to accept an already operational pre-certification and utilization review program.

The proposed regulations, combined with the cutting up of many states into numerous PSRO areas, added to the discontent. Even in areas where medical organizations have been working actively on implementing the PSRO law, rumors of discontent and even some calls for out-right boycott were being heard.

In a letter to its entire membership, the Ohio State Medical Association quoted extensively from a letter directed to HEW by the 12th Ohio District Congressman Samuel L. Devine. The Congressman pointed out that division of Ohio into nine PSRO areas rather than a single state area "is especially disturbing in view of the fact that the representatives of organized medicine have tried to cooperate with the federal authorities in making PSRO work in the state of Ohio." He went on to emphasize that Ohio physicians had already devised a sophisticated Peer Review system with regional representation, specialty panels, insurance committee, computer committee, hospital committee, a representative Board of Trustees and many resource personnel.

Devine warned HEW, "This (Ohio) program of peer review could well be destroyed as a result of imprudent governmental decisions. This loss would be wasteful, divisive, and perhaps irreparable, by polarizing the physicians to react negatively to voluntary participation in a peer review program."

On another front, the William K. Kellogg

Foundation, endowed by the breakfast food empire, announced a million dollar plus award for a two-year demonstration project involving six prototype PSROs. The award went to the American Society of Internal Medicine in cooperation with the American Association of Foundations for Medical Care, the American College of Physicians and the American Hospital Association. All four participating organizations are co-equal partners in managing the project.

In a memorandum to all of its component society presidents, the ASIM stated that the endeavor "has the endorsement of federal PSRO officials as well as the AMA and other specialty groups." It went on to point out that the "six locals to be selected (for PSROs) must be geographically separate and of different population density; some will be local, some statewide. Most important, they must display evidence of previous involvement in, or present enthusiasm and opportunity for an active, cooperative peer review effort."

The memorandum then went on to urge each ASIM component society president to give consideration to nominating his own area to serve as one of the six prototypes.

One of the first responses to the HEW listing of professional standards review areas was from the AMA. It immediately requested additional time for comment on the proposed regulations. The regulations, which would lead to the establishment of 182 PSROs, were published in the December 20th Federal Register and thirty days were given for comment by interested parties. In mid-January, the time of this writing, it was not known whether or not the extension was granted. However, a number of states that were designated as multiple PSRO areas, had expressed the intent of vigorously opposing the regulations. □

## Erratum

In the January, 1974 issue of *The Journal*, Doctor David P. Campbell's school of graduation should have been listed as the University of Rochester. Also, on page five of Doctor Campbell's article, the first paragraph of the right hand column should have been the last paragraph under the subheading of "Tracheoesophageal Fistula." The staff regrets these errors. □



## DOCTOR, WHAT WILL YOU EARN?

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## **"Killer - Cancer" Will Be Shown March 11th**

Continuing a series of medical documentaries presented by PBC-TV will be the presentation of "Killer — Cancer" to be shown on March 11th from 8:00 to 9:30 p.m. These programs have been designed to inform the public of methods of prevention, early detection and treatment of five medical conditions which account for 75.7 percent of deaths in the United States.

Cancer will strike one out of every four Americans at some time during his or her life. It is the nation's second largest killer.

The National Cancer Act of 1971 set the stage for what was promised as a "billion dollar fight to conquer cancer." Whereas many individuals held out great hope for a "quick cure," cancer specialists are far more cautious. The unhappy truth is that over 60 percent of people afflicted with cancer — excluding that of the skin — die from it. Almost half of all women who get breast cancer will die from the disease; the fatality rate is approximately 50 percent for men and women who have oral cancer as well as cancer of the kidney or bladder. Virtually everyone who gets stomach cancer dies from this dread disease, and the survival rate is only 9 percent for those afflicted with lung cancer.

In the area of prevention, scientists are looking at the environment, at foods, and at hereditary disposition toward certain tumors. At the basic research level, they are probing the character of the tumor cell to find out why it grows out of control and are stepping up the search for elusive viruses that are suspected of causing some human tumors.

At the bedside, they are improving the kinds of treatment — and are giving new attention to the rehabilitation of cancer patients maimed by surgery, drugs, or the disease itself.

Although "cure" is a strong word, doctors believe that nearly a dozen known types of cancer can be cured, mostly with a battery of new drugs in delicate combinations with each other. These "curable" cancers include several forms of leukemia and lymphoma that strike children, Hodgkin's disease, which afflicts young adults, as well as cancer of the placenta, cervix and skin.

Combination drug therapy, while holding out hope, seems to work best only in the hands

of a few specialists. Centers for cancer treatment now need to be spread across the country so that more people will have easier access to the best — and latest — therapy, in the hands of experts. Fifteen cancer centers are slated to go into operation around the country by 1975, but there is much more to be done.

Practicing physicians need to know more about who the experts are; individuals need to seek means for early detection; and communities must look into environmental causes. These are among the subjects covered on the Cancer show in "The Killers" series.

The Medical Advisory Board for Cancer: Mr. Alan C. Davis (vice-president), American Cancer Society; Mr. Sol Speigelman, PhD. (director), Institute for Cancer Research; Doctor Frank J. Rauscher, Jr. (director), National Cancer Institute; and, Doctor Vincent DeVita (chief medicine branch) National Cancer Institute. □

## **Changes Announced In Controlled Substances Act**

Three barbiturate drugs have been placed under Schedule II in the Controlled Substances Act by the Drug Enforcement Administration. The move will place stricter controls over the manufacture and distribution of the products.

DEA, the super agency created to coordinate all drug law enforcement, moved amobarbital, secobarbital and pentobarbital from Schedule III into Schedule II after it reviewed a 100-page report which cited 1,771 barbiturate suicides and deaths and 3,475 overdose and injury cases in 32 states during a 17 month period ending last year.

Movement of the barbiturates into Schedule II was not a surprise. Last November methaqualone, a hypnotic-sedative that is not considered as dangerous as barbiturate, was moved to Schedule II. At that time there was speculation regarding stricter controls over all barbiturates.

As a Schedule II drug certain restrictions will be placed upon dispensing and prescribing by physicians. Schedule II substances are those that are described as having a "high potential for abuse," but at the same time have a "currently accepted medical use in the United States . . ." Drugs formerly known as Class A Narcotics are contained in Schedule II. It also contains the amphetamines, methamphetamines, phenmetrazine and methylphenidate.



Prescriptions for Schedule II items may be filled only by a pharmacist pursuant to a written prescription. Schedule II prescriptions may not be refilled and any item in this schedule stored in a physician's office must be kept in a "securely locked, substantially constructed cabinet."

A separate record must be maintained on Schedule II items which a physician either administers or dispenses. It is not a requirement of the law that he keep a record of his prescriptions. However, it is recommended that he do so for his own protection. □

## HEW Orders Medicare Fee Standards Released

Medicare prevailing charge standards will be released to the public under an interim procedure set up by HEW's Bureau of Health Insurance. Under the procedure, which will remain in force while HEW officials work out a permanent format for requesting and releasing prevailing charge figures, news reporters and the public may receive physician's "screens" as computed in each region or state. As soon as the announcement was made the OSMA Peer Review Committee requested a copy of the prevailing information for Oklahoma.

"Screens" are the amounts judged to be the maximum acceptable fee for each medical procedure for which Medicare will pay its 80 percent reimbursement. The move by HEW to release the information was prompted by the loss of a federal lawsuit in the US District Court for the District of Columbia. A news man sued HEW to receive the information contending that it was a violation of the freedom of information act for the department to continue to withhold the data from public scrutiny.

The interim policy established by HEW for release of the fee standards data does not apply to the customary charge data for individual physicians. The final order of the district court was for HEW to produce their "reports on prevailing doctor's fees" and did not mention "customary charge" data.

As soon as the interim rules were announced the OSMA's Peer Review Committee made a formal written demand on the Medicare carrier for Oklahoma, Aetna Life and Casualty Com-

pany, for a copy of the prevailing fees in Oklahoma's five socioeconomic areas.

The interim rules for release of the information state generally that copies of the prevailing fees will be made available to those that request the information in writing or who choose to inspect the "screens" in person at a Medicare regional office or carrier office. However, no figures will be given by telephone and the carriers may charge at a rate of 25 cents per page to photocopy information totaling more than ten pages.


Personnel working for the various carriers hastily point out that all prevailing charge information is subject to almost continuous change. A constant internal tabulation and calculation by the Social Security Administration computer turns up errors in the prevailings that create changes, in addition to the usual official updates of the data every six to twelve months. Provisions are also made to adjust the prevailings whenever it is discovered that they are skewed because of some unique circumstance. □


## Alcohol Safety Action Project Issues Drinking - Driving Chart


The chart below has been issued by the Oklahoma City Alcohol Safety Action Project. The information should be considered only as a general guide, and is not intended as a fool-proof "Drinking-Driving Chart." Other factors may also influence the amount of alcohol that can be consumed with relative safety.

At .10% a person is seven times more likely to cause an accident than a sober driver. At .15% a person is 25 times more likely to cause an accident.

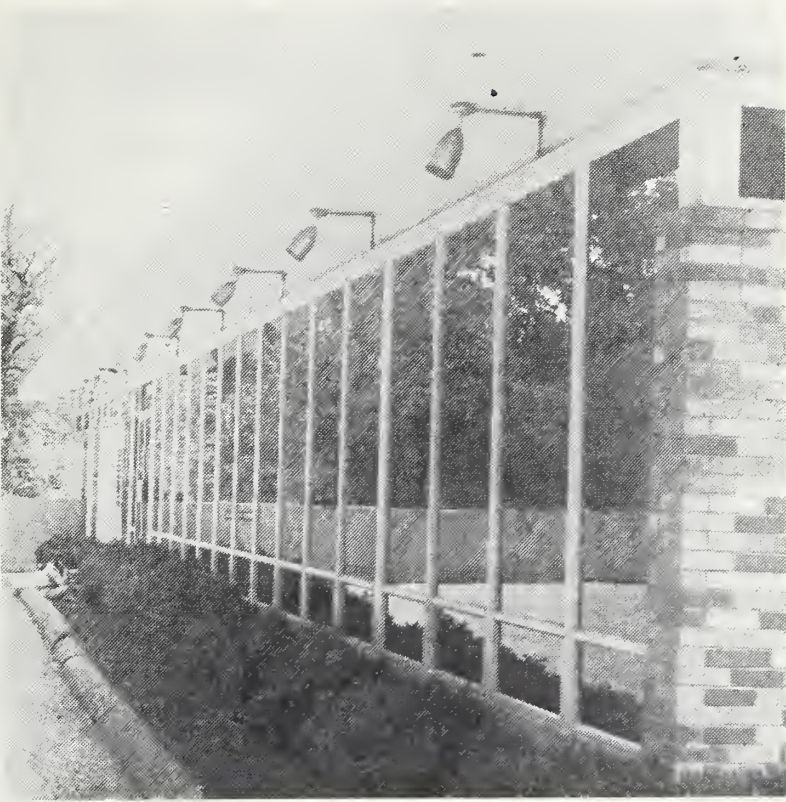
Weight	DRINKS (Two Hour Period)											
	1½ ozs. 80° Liquor, 12 ozs. Beer, or 4 ozs. Wine											
100	1	2	3	4	5	6	7	8	9	10	11	12
120	1	2	3	4	5	6	7	8	9	10	11	12
140	1	2	3	4	5	6	7	8	9	10	11	12
160	1	2	3	4	5	6	7	8	9	10	11	12
180	1	2	3	4	5	6	7	8	9	10	11	12
200	1	2	3	4	5	6	7	8	9	10	11	12
220	1	2	3	4	5	6	7	8	9	10	11	12
240	1	2	3	4	5	6	7	8	9	10	11	12

  
PRUDENT  
BAC TO .05

  
DRIVING IMPAIRED  
.05-.09

  
DO NOT DRIVE  
.10 & UP





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## Phase IV Health Regulations Finally Here

After several false starts, the Economic Stabilization Program has published its Phase IV health regulations issued by the Cost of Living Council. Released January 16th, the new regulations provide that physician's fees, previously limited to an aggregate 2.5 percent increase, would be limited to a total increase of 4 percent on the physician's entire annual practice income.

The Phase IV health regulations were an on again-off again proposition for sometime. Initially the regulations were slated for release on December 1st with implementation on January 1st. At the last minute the regulations were withdrawn and implementation postponed. Cost of Living Council staff members stated that during the public comment period between the time regulations are proposed and become operational, they received and analyzed more than 1,700 comments from concerned health care providers.

Interestingly enough, the Economic Stabilization Act, and therefore the Cost of Living Council statutory authority is scheduled to expire on April 30th, 1974. Whether or not Congress will hastily enact an extension to ESA is not known at this time (late January).

The final regulations, as were originally proposed, limits physicians, dentists, and other practitioners to an annual aggregate fee increase of 4 percent. Fees for specific procedures, however, could be increased by 10 percent for specific services over \$10 or by up to a \$1 annual increase for services under \$10.

Physicians may accumulate price increase entitlements from year to year. However, if a physician uses price increase entitlements from 1972 and 1973, 2½ percent per year, he must be able to cost justify that increase. The 4 percent increase under Title IV does not require cost justification.

A schedule of prices and a posted notice of availability of the schedule are required under Phase IV.

The American Medical Association had originally requested that physicians be exempted from control and pointed out that the program "imposes controls on physicians while other professionals are decontrolled. Moreover, ex-

emption from price controls have been granted to small firms . . . while denying equal treatment to 190,000 physicians in such firms." □

## Physicians Support Medical Education By Contributions

One of the best arguments against the myth that the AMA and physicians attempt to control the output of medical schools is the amount of contributions received by the AMA's Education and Research Foundation. During 1971, AMA-ERF made grants totaling \$1,100,000 to 112 medical schools.

Established in 1962, the foundation had as its purpose the fostering of medical education, medical research, and to assist young people in the financial aspects of their medical training. During the period 1962-1971, more than 46,000 loans totaling over \$51,000,000 have been guaranteed by AMA-ERF.

"A Million For Millions" is the motto being used by the woman's auxiliary nationwide in order to raise \$1,000,000 for AMA-ERF. According to Mrs. Scott Hendren, OSMA Woman's Auxiliary state chairman, Oklahoma has a minimum goal of a \$10 contribution per member.

Contributions to AMA-ERF may be restricted or unrestricted. Physicians wishing to make contributions to specific medical schools may do so through the foundation. It is only necessary to send instructions with the contribution as to which school is to receive the money.

Unrestricted contributions are used to help underwrite loan guarantees and to build up the medical school funds.

In either event, contributions to AMA-ERF are tax deductible.

Persons wishing to route their contributions through the Woman's Auxiliary may do so through their county society woman's auxiliary AMA-ERF chairman or the donations may be sent directly to the state auxiliary chairman, Mrs. Scott Hendren, in care of 601 N.W. Expressway, Oklahoma City, Oklahoma 73118.

Contributions may also be sent directly to AMA-ERF in care of the American Medical Association's office at 535 North Dearborn Street, Chicago, Illinois 60610. □



## DEATHS

WALTER G. HATHAWAY, MD  
1875-1973

One of Oklahoma's pioneer doctors, Walter G. Hathaway, MD, died December 1st, 1973. Born in Bells, Tennessee, Doctor Hathaway graduated from the University of Arkansas School of Medicine in 1910. With the exception of a short time in Provence, Oklahoma, he had practiced in Lone Grove until his recent retirement.

Doctor Hathaway had captured the admiration and love of the small Oklahoma community for his long years of devoted service to its citizens. He had received dual honors from the Oklahoma State Medical Association: A Fifty-Year Pin was awarded in 1955, for over a half century of service and an Honorary Membership was presented in 1956 in recognition of the outstanding service he had rendered to humanity and the medical profession.

HARRY C. FORD, MD  
1908-1974

Harry C. Ford, MD, Miami ophthalmologist, died January 23rd, 1974. Doctor Ford had practiced his specialty in Oklahoma City from 1936 to 1949 before moving to Miami. Born in Middleton, Missouri, he was graduated from the University of Oklahoma College of Medicine in 1933. Doctor Ford was a member of the International College of Surgeons and the American College of Surgeons.

HUGH C. JONES, MD  
1894-1974

Hugh C. Jones, MD, former Oklahoma City physician, died January 21st, 1974, in Laurel, Mississippi, where he had moved last year. A 1923 graduate of Northwestern University Medical School, Doctor Jones had been honored by the Oklahoma State Medical Association in 1973. He was presented a Life Membership for his outstanding service to humanity and his profession.

SAMUEL M. DAVIS, MD  
1925-1973

A 48-year-old Chickasha physician died December 21st, 1973. A native of Eldorado, Arkansas, Samuel M. Davis, MD, was graduated from the University of Oklahoma College of Medicine in 1956. He established his practice in Chickasha in 1958. Doctor Davis was member of the Blue Key, a national honorary fraternity.

WILLIAM H. DOYLE, MD  
1909-1973

Muskogee dermatologist, William H. Doyle, MD, died December 23rd, 1973. He had practiced in Muskogee since 1939. Born in St. Louis, Missouri, in 1909, Doctor Doyle was graduated from Washington University School of Medicine in 1934. His medical affiliations included the American Academy of Dermatology. □

*REMEMBER THESE DATES*

May 12th-15th, 1974

**OKLAHOMA MEDICAL SUMMIT**





## OSMA Tennis Tournament Set

The annual Tennis Tournament sponsored by the association will be staged on May 13th and 14th in connection with the "Oklahoma Medical Summit" medical convention in Oklahoma City, according to Farris W. Coggins, MD, tournament chairman.

"Oklahoma Medical Summit" is a consolidated annual meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society, and the Oklahoma Academy of Family Physicians. It will be held at the Myriad Convention Center and the Skirvin Plaza Hotel, May 12th-15th, and is expected to draw 4,000 medical and paramedical registrants.

Tennis, rapidly becoming the most popular sport among physicians, will prevail at the Oklahoma City Tennis Center, 3400 North Portland, Oklahoma City on Monday and Tuesday, May 13th and 14th, with play beginning at 9:00 a.m. each day for physicians' wives and at 1:00 p.m. each day for the men. Singles and doubles competition will be offered to both groups. Ten courts have been reserved for tournament play.

Handsome trophies will be awarded to winners.

Serving with Doctor Coggins on the tournament committee are Lanny Anderson, MD, of Oklahoma City; Lee Ison, MD, of Midwest City and Howard E. Hagglund, MD of Norman.

In addition to the Tennis Tournament, a Golf Tournament will be held in conjunction with Oklahoma Medical Summit. Additional details on the Golf Tournament will be announced prior to the May 12th opening date of the meeting. □

## Medical Schools Report Continued Growth

Significant increases in total enrollments of American medical schools were again reported during the 1972-73 school year. The University of Oklahoma College of Medicine started 1973-74 with 146 freshmen medical students.

First-year enrollment in 1972 nationwide increased by 1,335 to a total of 13,726. Total medical school enrollment in all classes was 47,546, an increase of nearly 4,000 students over the previous academic year.

The 1972-73 increase was achieved by both opening new schools and by expanding enrollment at many of the existing schools. Total number of medical schools in the fall of 1971 was 108. Three new schools opened in September of 1972; another in January, 1973; another in June, 1973; and another in September, 1973, for a total of 114 available to accept students for the 1973-74 academic year.

The number of graduates in the class of June, 1973, reached an all time high of 10,391, nearly 900 more than the previous year.

Medical school enrollment in the United States has been increasing steadily for more than ten years and at an even more rapid rate in the past six years. In the early 60s enrollment grew about 500 per year, but began a rapid increase in 1967 with 1,115 students. In 1968 it was up to 1,295; in 1969 it jumped to 1,836 and it went over the 2,800 mark in 1970. Enrollment increase by 1972 reached 3,896.

It is now anticipated that first-year enrollment should exceed 15,000 by the 1976-77 academic year.

Planning is underway for 16 new medical schools, with two already funded by the state of Ohio at Wright State University, Dayton, and in Northeastern Ohio at the Universities of Akron, Kent State and Youngstown State. It is possible these two could be open for enrollment in 1974 before the start of the academic year in 1975. □

## Frohlich Named Editor Of Research Journal

Doctor Edward D. Frohlich, Professor of Medicine and Physiology and Biophysics, and Director of the Division of Hypertension in the Department of Medicine at the University of Oklahoma Health Sciences Center, has been named Editor of the *Journal of Laboratory and Clinical Medicine*. The journal is the publication of the Central Society for Clinical Research.

Three associate editors from the medical center were also named to assist Doctor Frohlich. They are Robert M. Bird, MD, Dean of the College of Medicine; Leonard P. Eliel, MD, Professor of Medicine and Head of the Endocrinology Section of the Department of Medicine; and, Solomon Papper, MD, Senior Medical Physician at the Veterans Administration Hospital. □



## American College of Physicians Schedules Course On Critical Care

The Department of Medicine, University of Oklahoma Health Sciences Center, will sponsor an American College of Physicians Postgraduate Course on Critical Care Medicine, March 25th-29th, 1974. The five-day course will be held at the Lincoln Plaza Inn, Oklahoma City.

This course has been planned to extend the knowledge of those professional people who are regularly facing the challenge of Critical Care Medicine and *not* as an introduction for physicians and nurses in the work. The number of participants is being limited so that, in addition to the formal lectures, a number of small conferences will be directed at teaching the attendants skills and allowing them to have close contact with the instructors.

Attention will be given to the major critical care aspects of pulmonary medicine, cardiology, renal diseases, G.I. disease, infectious disease and shock.

Director of the program will be Robert M. Rogers, MD. Member fee registration (including residents and research fellows) will be \$140.00. Non-member and associate-member fees will be \$200.00 and \$70.00 respectively. □

## Book Review

**ETHER AND ME OR "JUST RELAX."** Will Rogers. Edited with an Introduction by Joseph A. Stout, Jr. 64 pp., illus. Stillwater, Okla.: Oklahoma State University Press, 1973. \$6.50.

This is the first volume of THE WRITINGS OF WILL ROGERS. After scholarly preparation the series is being published by the Will Rogers Commission and Oklahoma State University. This account of the author's gall bladder operation first appeared under the title "A Hole in One" in the *Saturday Evening Post* on November 5th and 12th, 1927. With the new catchy title, G. P. Putnam's Sons published the book in 1929 and many reprints thereafter.

The present edition includes a reproduction of the original manuscript. Every native and adopted Oklahoman will find Will Rogers' uninhibited idiom to be even more charming and amusing than the published version. He suggested the title "Scarbelly." Throughout he pokes fun at doctors, nurses, hospitals and health insurance. In this era of professional self-examination and governmental investigation, not to mention national political crisis, we would all be better off with another Will Rogers. A fresh look at ETHER AND ME is strongly recommended. *R. Palmer Howard, MD* □

## Miscellaneous Advertisements

**MEDICAL UNIT AVAILABLE** (900 sq. ft.). Located adjacent to Valley View Hospital and is ideal for an ophthalmologist or other practicing physician. City has a fine school system and a state college. Medical practicing area consists of 75,000 people. Contact Billy R. Bryan, 1201 E. 5th Street, Ada, Oklahoma 74820. Phone 405 332-4455.

**EXCELLENT OPPORTUNITY** for general practice in nice community near Lake Eufaula. Privileges in modern 44-bed hospital. Space available for GP in clinic adjoining hospital that already has an abundant pa-

tient-load. Can expect full-time practice in a short time, along with time off coverage. Guaranteed starting salary — very rapid chance of advancement — with capabilities of earning up to \$50,000.00 yearly. Call Carlton E. Smith, MD, 918 652-3337, Henryetta, Oklahoma, collect.

**BOARD CERTIFIED**, 31-year-old pediatrician, would like partnership or group practice in Oklahoma with other pediatricians. Will complete military obligation in September, 1974. Contact Hal Vorse, MD, 130 Station Hospital, APO New York 09102. □



# What's on your patient's face.

may be more important than his chief complaint

Patient P.T.\* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.\* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

\*Data on file,  
Hoffmann-La Roche  
Inc., Nutley, N.J







Mrs. Gerald Zumwalt

Your legislation committee had several goals for this year, 1973-74. Hopefully by now, we have geared ourselves and begun to make an organized effort toward supporting candidates of our choice, particularly candidates who are

"friends of medicine." One of our goals has been to help auxiliary members to be better informed and more decisive about those candidates we will be meeting in Oklahoma in 1974, as well as learning the why's and wherefore's of medical legislation before our national congress and state legislature in 1974.

We would urge all of you to join AMPAC-OMPAC now. PAC (American Medical Political Action Committee and Oklahoma Medical Political Action Committee) is a non-partisan group whose only purpose is to help elect good people to public office regardless of party affiliation. The organization helps and encourages friends of medicine in political endeavors. Now is the time for us to begin thinking about working toward electing honest people who are needed on the political front. Political action is what the PAC movement is all about. AMPAC-OMPAC needs your support now financially and in man-hours.

The Oklahoma Legislature convened in early January, 1974. Your legislation co-chairmen are at the present time co-ordinating efforts with Dave Bickham at the OSMA office to organize a "Day at the Legislature." Our ideas are on the table. Now we are working on a date, about which you will all be informed, and gasoline shortage permitting, auxiliary members will be meeting at the State Capitol to visit the Senate and House Chambers and to have lunch with our own Senators and Legislators in March or early April.

Mrs. Rose Gardner, National Legislation Chairman, was our guest at the mid-winter board meeting of the auxiliary in January. We were pleased and grateful to her for taking the time to come. Her enthusiasm would have served as an incentive to all of you and her knowledge about the legislation before our Na-

tional Congress would have been very encouraging if you could have been present.

We had little support in our efforts to set up a "LEGS-line Alert." This was disappointing because it would be effective as well as fun. But it takes so much co-operation and time to set up, that we just were unable to find those people who would be willing to take it on. We haven't yet given it up though, so if you are interested, let us know, and perhaps it could be set up by fall in time for the 1974 election.

We have a "world of material" at your disposal if you should want it. We have pamphlets that tell all of the "What's, Why's, and How's" of a campaign in addition to the current mail-outs on legislative issues. Don't allow yourself to be misled, misinformed, or worse yet, uninformed, while we probably have available just the item to clear up a matter for you.

Many legislative bills need our attention, either through our being aware of their existence and being knowledgeable about them, or through making direct contact with our Senators and Congressmen by letting them know our opinions.

In June of 1974 many health bills will expire. We need to apprise ourselves of this expiring legislation. The PSRO (Professional Standards Review Organization) is a public law. It is awaiting guidelines so that implementation can move onward. National health insurance looms on the horizon. All auxiliary extension programs are touched, either directly or indirectly, by what happens in the halls of the Congress in Washington or in our State House.

Voices and opinions do count. This auxiliary voice must first be knowledgeable, then we must show the proper concern. To be most effective, we must use the vehicle with the greatest numbers of auxiliary members that is possible.

Remember there is something for you to do. Be informed. Write your Congressman. Ask your friends to communicate with their Congressmen. Give financial aid and work diligently in the upcoming campaigns. *Mrs. Gerald Zumwalt* □



**The medical profession has recouped some of its lost public esteem.** Two recent surveys indicate that 57 percent of all those polled expressed a great deal of confidence in the medical profession. Other rankings were universities, 44 percent; TV news, 41 percent; military, 40 percent; US Senate, 30 percent; the press, 30 percent; major companies, 29 percent; **US House of Representatives**, 29 percent; **labor**, 20 percent; executive branch of the federal government, 19 percent. In another poll 2,200 adults were asked to list nine professions in order of admiration and esteem. Physicians were first, scientists second, clergymen third. One wag was heard to say, "I'm not sure we are regaining our esteem, I think everyone else is losing theirs."

**Phase IV is here.** Cost of Living Council regulations regarding physicians have been issued. A news article appears on page 74 in this issue of *The Journal* on Phase IV. Under the regulations a physician may raise his fees 4 percent annually, provided the fee does not raise his profit margin. Any fee for an individual service over \$10 is limited to a 10 percent annual increase, for services less than \$10 the increase may be up to \$1. The new rules eliminate cost justification as a requirement for price increases, however, they do require that a physician post an easily readable sign stating the availability and location of a fee schedule.

**It costs more to go first class**, especially when you are talking about the United States Mail. On March 2nd the price of mailing a first class letter will go up to 10 cents. Postcards will jump from 6 to 8 cents, and the cost of an airmail letter will go from 11 to 13 cents. Originally the price increase for postal services was to go into effect on January 5th. However, the Cost of Living Council directed that the Postal Service could not raise its fees at that time. But, March 2nd is the new postal rate increase date. Numerous other increases for second, third and fourth class mail will also be included in the increase.

**Maybe saccharin is safe after all.** At least a recent report from the National Institute of Environmental Health Sciences says that those concerned with the risk of cancer from the consumption of saccharin may be relieved to hear that there is no accumulating of the sugar sub-

OSMA

JOURNAL / *the last word*

stitute in the tissues if the sweetener is withdrawn from the diet for three-day periods every other week.

**Tough talk is coming from the AMA.** Russell B. Roth, MD, AMA President served notice on HEW Secretary Casper Weinberger that if the Department attempted to implement proposed regulations establishing a pre-admission certification program for Medicare and Medicaid patients, the AMA would see them in court. Stating that the proposed regulations were "... wrong medically, wrong morally, and wrong legally.", the AMA official stated that the association would seek an injunction to stop implementation of the unpopular regulations. He said that they would seek support from senior citizen organizations and consumer groups, "but with them or without them, we will be in court on the day those regulations are promulgated."

**A drug overdose treatment film, "What Did You Take?"**, is available from the OSMA for showing to medical societies, hospital staffs or any interested medical group. Also, the OSMA's Drug Abuse Treatment Manual, second edition, now is available in small quantities. Manual orders and film arrangements may be made by contacting the association office in Oklahoma City.

**"The Business Side of Medical Practice"** is a new **AMA book** designed for the physician who is considering a private practice. An updated version of an earlier AMA publication, the book offers basic information on accounting, bookkeeping, real estate, tax law, insurance and personnel management. It also contains information on office record keeping and technical equipment, system for scheduling, sample office forms and check lists, and an analysis of the advantages and disadvantages of solo, group and corporate practice. Orders for publication #OP-410 may be placed through the Order Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Single copies are \$1.25. □



## *The Foreign Medical Graduate, A Blessing or A Risk? Part II*

In a previous editorial we have reported how through a sleight of hand the highest officials of HEW transformed our shortage of physicians into an inexpensive soon-to-be achieved surplus, essentially by relying on the ever increasing influx of foreign graduates (FMG's). The recent ban on the export of oil by a fair-sized number of relatively underdeveloped countries should teach us that other underprivileged countries also might embargo a different vital commodity, i.e. medical manpower, albeit for different reasons, and that it is very hazardous to rely to an important degree on an undisturbed mass influx of foreign physicians.

For numerous reasons it is important to explore where the immigrating FMG's received their medical training. If we exclude Canadian graduates who, for purpose of statistics and licensure are regarded as American graduates, we find that in 1972, in contrast to the past, where Western Europe supplied most of the physician-immigrants, 65% received their medical training in Asia, particularly the Philippines, India and Korea, 16% in Central and South America, and only 14% in Europe. The rest came from Africa and formerly British islands.

The dramatic change in the overall number and origin of immigrating physicians can be explained by changes in U.S. immigration laws which abolished the quota system and established preferences for needed professions and occupations, by the economic recovery of Western Europe and by the attraction of high income and better medical-educational facilities of this country as compared to impoverished and underdeveloped countries in Asia, Central and South America. While frequent warm praise is voiced by American physicians of individual FMG's who have been able to develop the appropriate skills and adaptation that is required of American physicians, the reception, particularly of Asian doctors, by their American colleagues on the whole has not been too friendly and often is quite critical. This is especially noticeable in New York, New Jersey, Illinois and California where most FMG's have settled. To what extent is this criticism of foreign-trained physicians justified? As far as their overall professional

knowledge is concerned the answer can be derived from the data of the Educational Council of Foreign Medical Graduates (ECFMG). These data are based on the results of ECFMG examinations which include an English language test. While the candidate can retake the examination as many times as he wants, about one-third of all foreign graduates fail permanently after one or more tries. Even after they have passed the ECFMG examinations and have completed their traineeship as interns and/or residents, there is still a failure rate of 38% in the state licensure examinations. These not too gratifying results are complemented by other basic deficiencies of the foreign graduate. The FMG, particularly the Asian physician, comes from a considerably different background where ethical standards in regard to suffering and illness are not based on the Western philosophy of compassion and charity, (unfortunately honored not rarely in the breach), where there is a more fatalistic outlook on poverty, illness and the value of human life, where culture and social standards are unlike ours and finally where general education, including medical training, is different and commonly inferior to the American educational system. If we add to this the serious language difficulties and the cultural adjustment in life style required of the foreign graduate and his family, we understand that he can hardly be expected to equal his American counterpart.

It might be argued that passing the qualifying examinations, including a required mastery of the English language, compensates for the differences and deficiencies, but how can we test a candidate for ethics and compassion and for a full understanding of the spoken language, including the vernacular? If the candidate overcomes the formidable difficulties of the ECFMG tests and the state licensure examinations, he is most commonly accepted in an institution, such as an unaffiliated hospital, where his educational needs are subordinated to the services that he can render. No wonder that the foreign graduate is dissatisfied with his training experience and feels unhappy and exploited. This is also the reason why he quite frequently settles in a large urban



center, where he finds co-nationals and a more congenial environment. Central American physicians often prefer to start out—to the advantage of all concerned—in the ghettos of the inner cities, particularly metropolitan New York, Miami, or Los Angeles where his clientele is essentially represented by a Spanish-speaking population. To give an example: 28% of all FMG's practice in New York State, where two out of five physicians are graduates of foreign medical schools. For reasons given, FMG's are very reluctant to establish themselves in locations where there is a great and unmet need for physicians. Only 11% of FMG's settle in these less densely populated regions. What happens to FMG's who are unable to pass the qualifying examinations? They either return to their homeland or operate in a twilight zone of legality where they are employed as unlicensed doctors under the official supervision of qualified physicians, particularly in mental hospitals or as physician-aides and technicians. Their exact number is unknown, but goes into thousands.

Since it can be presumed that for quite some time to come we will have to rely to a considerable degree on FMG's to satisfy our health needs, we must ask ourselves if we have done all we can to integrate the foreign physicians and raise their medical competence during their formative years as trainees. The answer is definitely negative, particularly in the light of the previously discussed exploitation of FMG's as house physicians in unaffiliated service-oriented hospitals.

While no determined organized effort has been made to upgrade the quality of their education, there have been recent attempts to make the FMG and his family feel more at home by giving him and his wife the necessary orientation in socio-economic and practical problems of living. His status and tasks within his hospital environment should be clearly outlined to him. The Philadelphia program of integrating the foreign physician and his family into their new surroundings has been pace-setting. It includes participation of the house

and visiting staff's women's auxiliary. The trainee's mastery of the spoken English language should be improved and last, but not least, a solid medical educational program should be initiated. Part of the expenses of this educational program could be covered by the federal budget as partial repayment for the undergraduate and medical training of the FMG in poverty-stricken countries.

This brings us to the "brain-drain" of the health manpower resources of foreign countries, of which the United States has quite often been accused. Well motivated American physicians have in the harshest terms called attention to the "ruthless expropriation of physicians" from underprivileged countries that are desperately in need of health manpower. This is a reverse form of foreign aid, which makes us a recipient of foreign medical assistance from those who can least afford it. Technically the problem can of course easily be resolved by joined initiative efforts of the immigration authorities in the U.S. and the passport-granting agencies in the foreign countries. But both sides, each for its own reasons, have not resorted to drastic steps in restraining permanent emigration of foreign physicians to this country.

Most of the criticisms of our rapacious activities in this respect go back just a few years, when moral principles were still of influence in shaping our relations to underprivileged and developing countries.

This discussion should detract in no way from the need of offering postgraduate training of the highest order for physicians who are later returning to the country of their origin, which cannot afford such expensive and specialized instruction.

Summarizing this discussion we must recognize our somewhat hypocritical double standard which requires our American medical students to undergo the most rigorous and universally respected training before they can enter medical practice, while on the other hand we overlook the dilution of standards by accepting foreign undergraduate medical education as equal to ours and disregard other shortcomings in the postgraduate training program for foreign physicians. *Ernest Lachman, MD*





At last I have some good news. Due to the efforts of the AMA, the OSMA, and all of you, the members, the pre-admission certification for Medicare-Medicaid patients has been withdrawn from the Federal Register, reluctantly, by Mr. Weinberger.

We had excellent cooperation from the entire Oklahoma delegation. They responded to my letters and to your letters in protesting this very adverse admission order on our patients. I wish to take this opportunity to thank each and every one of you who wrote to your Congressman or to the departments involved in this, and I thank you for your cooperation. This is the type cooperation we need to defeat things in the national bureaucracy.

I am deeply disappointed in the amount of money coming into the OMPAC organization which is our political action group. Ed Calhoun and I, as well as other state members, will attend the national AMPAC conference in Washington, D.C., March 15th-17th. I am in hopes we will come back with many new ideas to help us.

The Watergate scandal in my opinion is going to lose us many friends in Congress. The COPE organization (Committee on Political Education, AFL-CIO) is already planning to have a candidate in every district in the US and they have the money to support an effort of this magnitude. If you haven't paid your OMPAC dues, please do so immediately. The

dues are \$20 annually. You should also send \$20 for your wife. A sustaining membership would be ideal . . . only \$100 annually. Please send \$100 (or a minimum of \$20) to OMPAC, P.O. Box 75341, Oklahoma City 73107.

The Summit meeting for May is shaping up as the best medical meeting ever held in Oklahoma. We will have the AMA President, Doctor Russell B. Roth, the American Academy of Family Physicians' President, Doctor James Price, and many, many outstanding speakers, exhibits and fellowship. Please make your plans now to come . . . if only for the kind of fellowship we need today more than ever.

The Oklahoma Foundation for Peer Review is diligently at work and will have a report to the Board of Trustees and also to the House of Delegates on the possibility of implementing PSRO in a manner to be controlled by the physicians. As all of you know, the House of Delegates has final authority on our PSRO policy. The discussions with the computer companies have been very informative. The committees have been working diligently on guidelines of treatment, and these are going to be terrifically important to all of us. When the examples come to the hospital staff, please check over them and send back your opinions to the OSMA office. □

Fraternally,

C. Riley Strong, MD



# Reduction Mammoplasty: A Comparison Of Techniques

BRUCE A. MacDOUGAL, MD  
EDWARD A. SHADID, MD

*Reduction mammoplasty is indicated for a definite pathological entity, macromastia, or hypertrophy of the breast, which presents with a specific chronic and functionally disabling syndrome. A review of the symptoms, etiology, and current surgical techniques is presented with particular emphasis on the technique preferred by the authors.*

## INTRODUCTION

When most physicians think of breast surgery, they think either of ablation of breast tumors or augmentation for small breasts. The purpose of this paper is to review a third aspect of breast surgery, the surgical treatment of massive breasts. These are defined as breasts weighing two to five pounds apiece and requiring usually a DD cup or even a custom-made brassiere.

## SYMPTOMS

Embryologically, the breasts originate from the dermis and are really enlarged skin glands. Throughout the parenchyma there is an interlacing network of fibrous septa called Cooper's Ligaments, which are firmly attached to the dermis of the breast and upper chest skin. As a

result, the breast is suspended almost entirely from the skin of the upper chest with a minimum of the weight borne by the chest wall. This is the most important factor in understanding the symptoms of macromastia. (Fig 1)

Anteriorly, the skin is mobile and slides over the underlying soft tissue. Posteriorly, the skin is immobile, thicker and firmly attached to the underlying muscle fascia by a network of connective tissue. Thus, as the patient stands erect, the pull of the breasts is transferred directly to the back and posterior neck. Excessive breast weight will cause excessive traction, pulling the shoulder girdle and the neck down. Although the forces at any given time are small, they are continuous for many hours each day and after many years can cause chronic musculoskeletal complaints. Fatigue and pain in the back of the neck and shoulders are chief complaints in most patients, especially those in the older age group. There is also a direct pressure on the top of the trapezius as the skin drapes over it. The distribution of forces is similar to that in a pulley apparatus with the pulley at the top of the trapezius. Although all of the weight is supported by the trapezius, the pull is distributed to the neck and back. A brassiere does not change these forces; in fact, it works on the same principle, concentrating the weight of each breast to the narrow area on the trapezius under each bra strap.

Ultimately, the skeleton bears the weight of the massive breasts. It is the skeletal framework against which their weight is pul-



ling. Here another physical analogy is applicable: the lever arm. The fulcrum is at the spine and the muscles which keep the spine erect have a poor mechanical advantage since they lie adjacent to the spine. The breasts, on the other hand, are located farther from the fulcrum than any other body structure and thus have a disproportionately large amount of torque. A relatively small increase in breast weight is greatly magnified in its effect on the back muscles and ligaments. The lever and pulley principles both affect the cervical and upper thoracic spine tending to cause a kyphosis. In fact, Conway<sup>1</sup> has three cases of localized hypertrophic osteoarthritis which improved following reduction mammoplasty. The lever arm principle also affects the lumbar spine and pain in the lower back is common, although it is rarely as severe as the upper back pain.

The musculoskeletal complaints are usually the most important symptoms of macromastia, especially in the middle- and older-aged patient, but there are several other common complaints. The size alone of the breast is often a major complaint. Oversized breasts tend to interfere with most normal activities. The breasts are frequently painful. Often there is a dense fibrous stroma throughout the breast parenchyma which is nonelastic and small volume changes will cause a relatively large increase in pressure making the breast tender and sore. This is common during menses although the breasts may remain painful for prolonged periods. Frequently, fibrocystic disease or adenosis may be associated with the hypertrophic breast causing pain. Most brassiere straps are thin and concentrate the full weight of the breast on a small area of each trapezius. This spot is well-grooved and usually chafed and sore. Frank ulcerations often develop which are difficult to heal unless the patient stops wearing a brassiere. Beneath the breast, hygiene in the submammary fold is difficult. There is always a large amount of perspiration and often frank intertrigo. This rash can be very resistant to normal curative measures.

In younger patients social and psychological pressures are very important. Macromastia may be embarrassing during the dating years and is frequently the brunt of painful locker room or schoolyard jokes. The breasts are unattractive with massive areola, prominent venous patterns, large stretch marks, and occasionally, heavy pigmentation. Finally, finding adequate

clothing is difficult and often must be custom-made.

In summary, there is a wide variety of physical symptoms and social stigmas attached to macromastia. In the two larger series of reduction mammoplasties<sup>6</sup> (Foged's 736 patients and Strombeck's 726 patients), the physical symptoms of muscular skeletal complaints, shoulder pains, and breast heaviness predominated in 90 to 95% of the patients. Eighty percent were concerned about their appearance. Complaints connected with sports and work were found in 50%, while 30% complained of breast pains and another 30% complained of submammary intertrigo. In the authors' series, most of the older patients have complained of the physical symptoms, especially the musculoskeletal discomfort, while younger patients tend to be concerned about their appearance and the limitation of their activities.

#### ETIOLOGY AND PATHOLOGY

Macromastia may be associated with several abnormalities, the most common of which are: (1) granulosa cell tumors of the ovary, (2) theca cell tumors of the ovary, (3) adrenal cortical disturbances in tumors, and (4) hypothalamic lesions. In all of these conditions, macromastia is only one of a number of disturbances involving the primary and secondary sexual characteristics. Most patients do not have any associated endocrine abnormalities, and a work-up is not routinely indicated.<sup>3</sup>

Most patients develop large breasts at puberty and the breasts slowly continue to increase in size, especially during pregnancies. Most patients have a tendency toward obesity. Breasts will increase during a time of weight gain by an average of 20 grams for each kilogram of body fat gained. Once the fat has been deposited in the breast, it is more difficult to lose than other fat deposits. Usually dieting cannot significantly reduce breast size. Nevertheless, most surgeons, including ourselves, recommend weight reduction prior to surgery when it is indicated. Heredity factors also play a large role in macromastia. Between 50 and 80% of all patients will have a positive family history.<sup>6</sup>

Examined microscopically, almost all of the tissues of a hypertrophic breast are either fat or fibrous stroma, with few ducts and glands. There is minimal difference in the total amount of glandular and ductal tissue in the small breast compared to the massive breast. The re-



#### SYMPTOMS

- (1) MUSCULO SKELETAL PAIN
  - (a) Neck and Upper Back (pulley principle and lever arm principle)
  - (b) Lumbar Spine (lever arm principle)
- (2) BREAST PAIN
- (3) BRA STRAP GROOVES
- (4) INTERTRIGO
- (5) PHYSICAL ENCUMBRANCE
- (6) PSYCHOLOGICAL PRESSURES IN YOUNG
- (7) DIFFICULTY OBTAINING CLOTHES

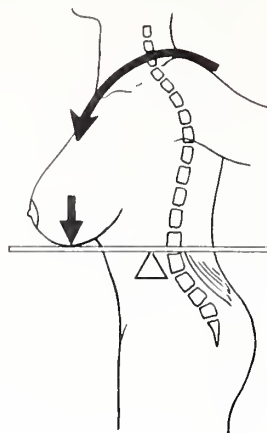


Figure 1 Symptoms

lative amounts of fat and fibrous tissue vary from patient to patient. Some will have primarily fat, while others will have thick, diffuse bands of heavy, fibrous stroma, often associated with ductal epithelial proliferation and cystic dilatation. Such breasts are usually painful. In the hypertrophic, as in the normal breast, there is a wide diversity of pathological diagnoses: fibrocystic disease, adenosis, cystic hyperplasia, adenofibrosis, fibrocystic mastitis, etc, which seem to represent different points along a broad spectrum. In the authors' series, the occurrence of fibrocystic disease is more frequent than normally reported.

The etiology of macromastia is not clear. The many hormones synergistically involved in mammary growth have been studied extensively. None have either an increased production or increased serum level in the patient with macromastia. All recent authors agree that macromastia is primarily an increased end organ response to the normal hormonal milieu. Why there is an increased fat and fibrous deposition has yet to be determined.

Two special forms of the disease should be mentioned. The first is unilateral hypertrophy, where one breast is massive and the other normal. This asymmetry is easily distinguishable from the subclinical variation normally found. The second, hypertrophy of pregnancy, is extremely rare, occurring much less frequently than unilateral hypertrophy. The breasts become massively enlarged during the second and third trimesters, weighing between five and ten pounds apiece, shrinking to long ptotic pendulums following delivery. The phenomenon recurs with each pregnancy. Most physicians feel this is a response to placental estrogens,

since the maternal blood level rises markedly at the end of the first trimester.

#### OPERATIVE PROCEDURES

Plastic surgery on the breast is recorded as early as 1669 when Dunsted did the first reduction—an amputation. The forerunner of today's operation dates to 1897, seven years after Halstead's report of his radical mastectomy, when Michael and Poussin resected wedges from the upper breast. In 1903 Guinard performed the first true reduction through submammary incisions. Over the next 25 years many operations were performed and the principles established for the two types of procedures most commonly used today: a free nipple graft, and transference of the nipple by use of a pedicle flap.<sup>5</sup>

#### *Free Nipple Graft: Procedure for Severe Macromastia (Fig 2)*

In 1922, Thorek suggested a partial amputation through a crescent-shaped incision whose lower border is just above the submammary fold. This wedge includes most of the breast tissue with the nipple and areola. A small buttonhole incision down to the dermis is made just above the incision. The nipple, areola and erectile tissue are transplanted as a free composite graft and held in place by a stent. A central vertical wedge is then taken so that the breast can be narrowed and the incision closed.

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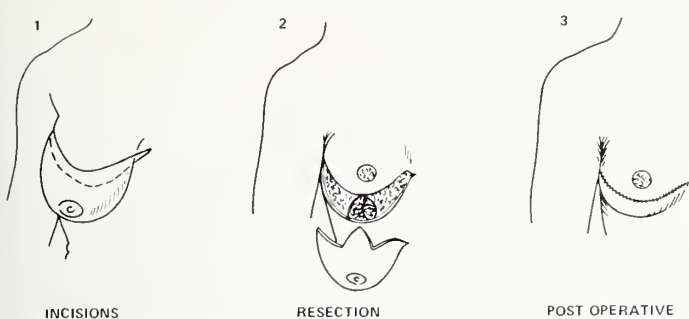


Figure 2. Amputation with Free Nipple Transplantation.

This basic procedure is still used today. Occasionally, ptosis is so great that an insufficient amount of breast tissue is left above the crescent-shaped incision. To add more bulk to the reconstructed breast, a tail of parenchyma can be left at the time of amputation and subsequently folded in under itself into the avascular plane between the chest wall and the breast tissue.

Partial amputation with a free nipple graft is unquestionably the safest procedure in cases of extreme macromastia. It is a simple, quick operation with a low complication rate, easily adapted to the most gigantic breast. However, the procedure does have several disadvantages. It is rarely possible to achieve a natural conical shape even by narrowing the breast with excision of the central wedge. There is a small incidence of graft ischemia, and at times frank slough. The nipple frequently has a markedly decreased sensation and contractility. Occasionally the nipple does not protrude, leaving the entire graft flat. The authors use this procedure only for gigantic breasts when more than three and one-half pounds of tissue are to be resected. We have removed as much as five pounds of tissue from each breast using this procedure. (Fig 3) The overriding concern in such cases is to relieve the patient of excess weight. The symptomatic relief is far more im-

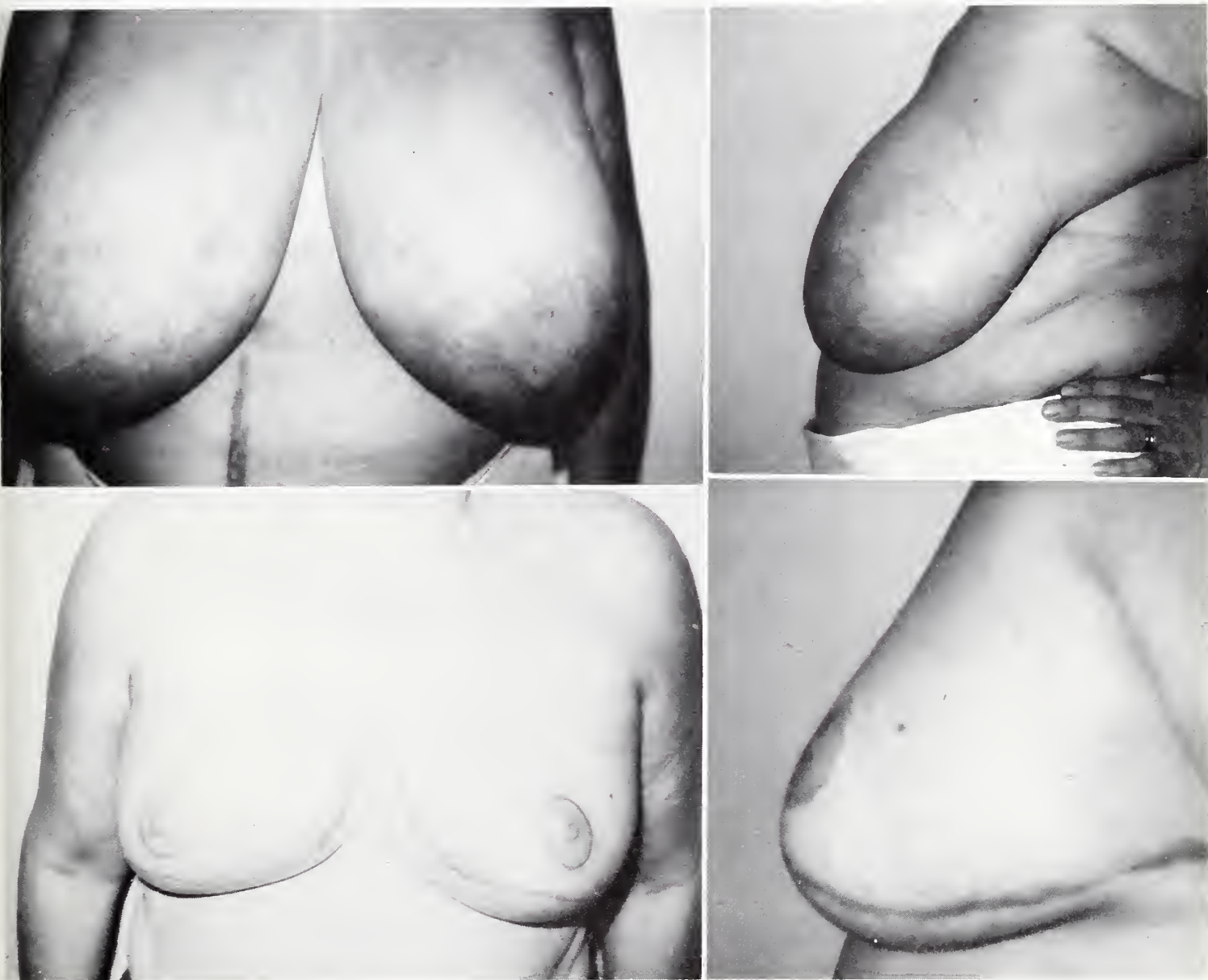


Figure 3. Amputation with Free Nipple Transplantation. A & B (upper) Pre-Operative. C & D (lower) Post-Operative.



portant than the disadvantages. Post-operatively, these patients are some of the most appreciative in a surgical practice. However, for less extreme cases other procedures are advocated.

*Pedicle Flap: Procedure for Most Cases of Macromastia*

As techniques for reduction developed, attention turned to maintaining a constant blood supply to the nipple by transferring it subcutaneously on a pedicle flap. De Vallandre, in 1911, and Duformetel, in 1916, described procedures utilizing pedicles of breast tissue. Unfortunately, breast parenchyma does not have enough blood supply to support the pedicle, so another source was needed. The skin with its rich dermal plexus was readily available and reliable. With careful dissection, the dermal blood supply is not injured and the pedicle can be folded upon itself and transferred subcutaneously without difficulty. The nipple maintains its normal sensation, its normal innervation, and a good blood supply. Procedures using this principle are favored by most plastic surgeons, since better aesthetic and functional results can be obtained. The breasts are narrower and have a more normal shape than those with a free nipple graft. More importantly, these procedures are more reliable in maintaining good nipple sensation and erectile tissue. (Table 1)

Postoperative lactation has been frequently discussed by surgeons, but rarely by patients. Obviously, with a free nipple graft there is none, and with a large resection, there is little. Most patients do not want to lactate again since lactation may mean enlarged, painfully engorged breasts. The authors have had no patients who have been concerned about breast feeding.

Table 1

COMPARATIVE ADVANTAGES:  
GRAFT VS. PEDICLE FLAP

**GRAFT**

- (1) Simplicity
- (2) May be used with gigantic breasts

**PEDICLE FLAP**

- (1) Good sensation
- (2) Functional erectile tissue
- (3) Conical shape
- (4) Narrower

NIPPLE TRANSPOSITION: STROMBECK METHOD

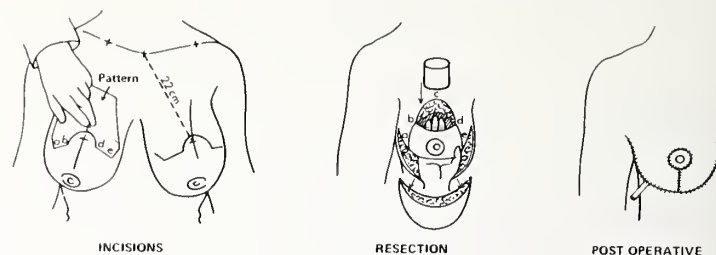


Figure 4 Nipple Transposition: Strombeck Method

The most popular procedure today was described by Strombeck.<sup>6</sup> A standard pattern is outlined on the upper breast. The inferior border of the pattern is indented (b-c-d) where the areola will lie after the reduction. The new nipple site is usually about 22 or 24 cm from the sternal notch at the mid-clavicular line. The lateral bases (a-b and d-e) of the pattern form two lateral flaps which will be pulled together under the areola to form the inferior portion of the breast. Lines are drawn from the inferior edges of the pattern to the lateral and medial edges of the submammary fold and then along the submammary fold itself until they join. This outlines a large wedge, including most of the breast tissue which is to be resected. A curved pedicle which includes the areola is then drawn from the two bases. The epidermis is dissected from this pedicle. When the inferior wedge of breast tissue is resected, the parenchyma under the pedicle flap is left intact but separated from the chest wall. A cylinder of breast tissue, outlined by the circle about the pedicle, is resected down to the chest wall and removed. The pedicle is then advanced into the empty space. The lateral flaps are undermined and rotated below the remaining breast tissue to form the inferior portion of the breast. This is the so-called "skin brassiere" which supports the new breast.

Many variations in this technique have been advanced but none have solved the problem of

NIPPLE TRANSPOSITION: LATERAL METHOD

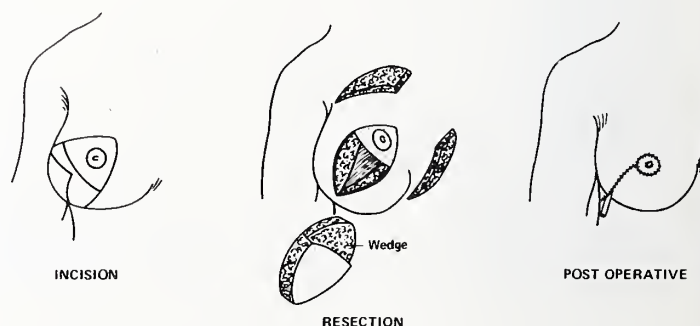


Figure 5 Nipple Transposition: Lateral Method



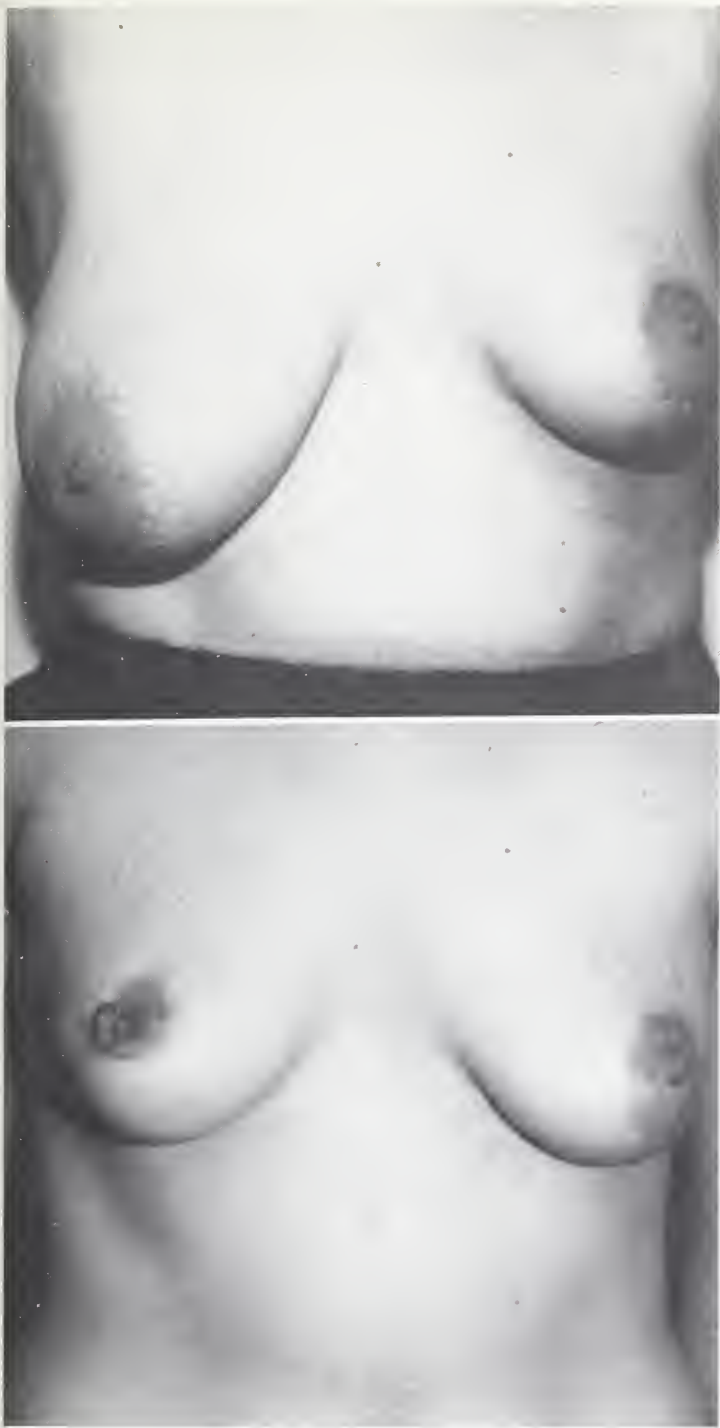


Figure 6. Assymetry of Breasts. A (upper) Pre-Operative. B (lower) Post-Operative Reduction Mammoplasty Right Breast.

the large scar extending 180 degrees around the base of the breast. This scar begins almost in the mid-line of the sternum somewhat above the level of the areola and extends the full distance of the submammary crease to the anterior axillary line. As noted in the diagram, the great length of these incisions medially and laterally are necessary to prevent a "dogear" of extra skin when the wedge of inferior breast tissue and skin are removed. The greater the reduction the higher these incisions must be. Like any scars on the upper chest wall, they are noticeable and are frequently hypertrophic. They are visible when a woman wears a moderately low-cut gown or bathing suit. This is one of the most frequent complaints about the Strom-

beck technique. There are several others. It is difficult to obtain a natural conical profile to the breasts. The new breasts tend to be flatter and wider than those resulting from other techniques, such as those of Pitanguy and Biesenberger.<sup>5</sup> In these last techniques, the entire breast skin is undermined just as the inferior flaps in the Strombeck technique are undermined. Unfortunately, whenever there is subcutaneous undermining, scar tissue forms and the adjacent tissue is stiffer and less mobile than normal. Finally, in all the techniques, the decision on how much breast tissue is to be removed must be made early in the operation, making it difficult to make small modifications at the end of the procedure to obtain a better breast contour or to readjust the nipple placement.

Recent literature abounds with variations of reduction mammoplasty procedures. Such an abundance suggests significant criticism of the current techniques. The only new approach which corrects most of these was suggested in 1961 by Duformental and Mouly.<sup>4</sup> This procedure also uses a pedicle flap and is now the one recommended by the authors in all reductions, except for gigantic macromastia.

The procedure uses a single infra-lateral incision. Two points are marked: the lower lateral at the junction of the submammary crease with the anterior axillary line and the second about two or three cm. superior and medial to the areola. These two points are joined by two curved lines. The superior line is made by connecting the points with a straight line while the hand pushes the breast down and in. The inferior one is drawn while the hand pushes the breast up and out. This forms a large ellipse which includes the areola. The areola is dissected free with a dermal flap and three to five cm. of underlying breast parenchyma. The remainder of the ellipse is excised down to the chest wall, including the portion underneath the flap. By closing the ellipse one can see the contour of the new breast. If further reshaping or reduction is necessary, wedges of parenchyma can be removed from the adjacent breast in the medial and superior aspects of the incision. The surgeon makes these decisions near the end of the procedure. The skin at the superior margin of the dermal pedicle is then undermined for two or three cm. The wound is closed in layers, closing the skin flaps over the nipple. A drain may or may not be used. Finally, the position





Figure 7. Moderate Hypertrophy of Breasts. A & B (upper) Pre-Operative. C & D (lower) Post-Operative Reduction Mammoplasty Lateral Method.

of the new areola is chosen at the apex of the breast cone. The undermined skin is excised and the areola and nipple are brought to the appropriate position. (Fig 6-8)

This procedure has five major advantages. (Table II) (1) Most importantly, the scar is much smaller and less obtrusive than the large, prominent scars of the other techniques. This lateral

scar extends only from the areola to the anterior axillary line or just beyond. There is no medial scarring. (2) The exact shape of the breast is determined at the end of the procedure, with the minor modifications made just prior to closing. This is extremely important to the surgeon when he is trying to achieve a natural and conical shape to the breast. (3) Exact nipple position is also determined at the end of the procedure, allowing accurate placement at the apex of the cone, matching with the nipple of the other breast. (4) Unlike other procedures, there is almost no skin undermining. Most of the undermined skin is resected when the areola is placed in its final position. Thus, the breasts are more natural in appearance and palpation. (5) This procedure is a relatively simple technique. A simple modification of this basic technique may be used for ptosis.<sup>2</sup> (Fig 9)

Table 2

#### ADVANTAGES OF LATERAL TECHNIQUE

- (1) No highly visible, objectionable medial scar. Small lateral scar.
- (2) Exact shape determined at end of operation
- (3) Nipple position determined at end of operation
- (4) No skin undermining
- (5) Relatively simple operation





Figure 8. Giant Hypertrophy of Breasts. A & B (upper) Pre-Operative. C & D (lower) Post-Operative Reduction Mammoplasty Lateral Method.

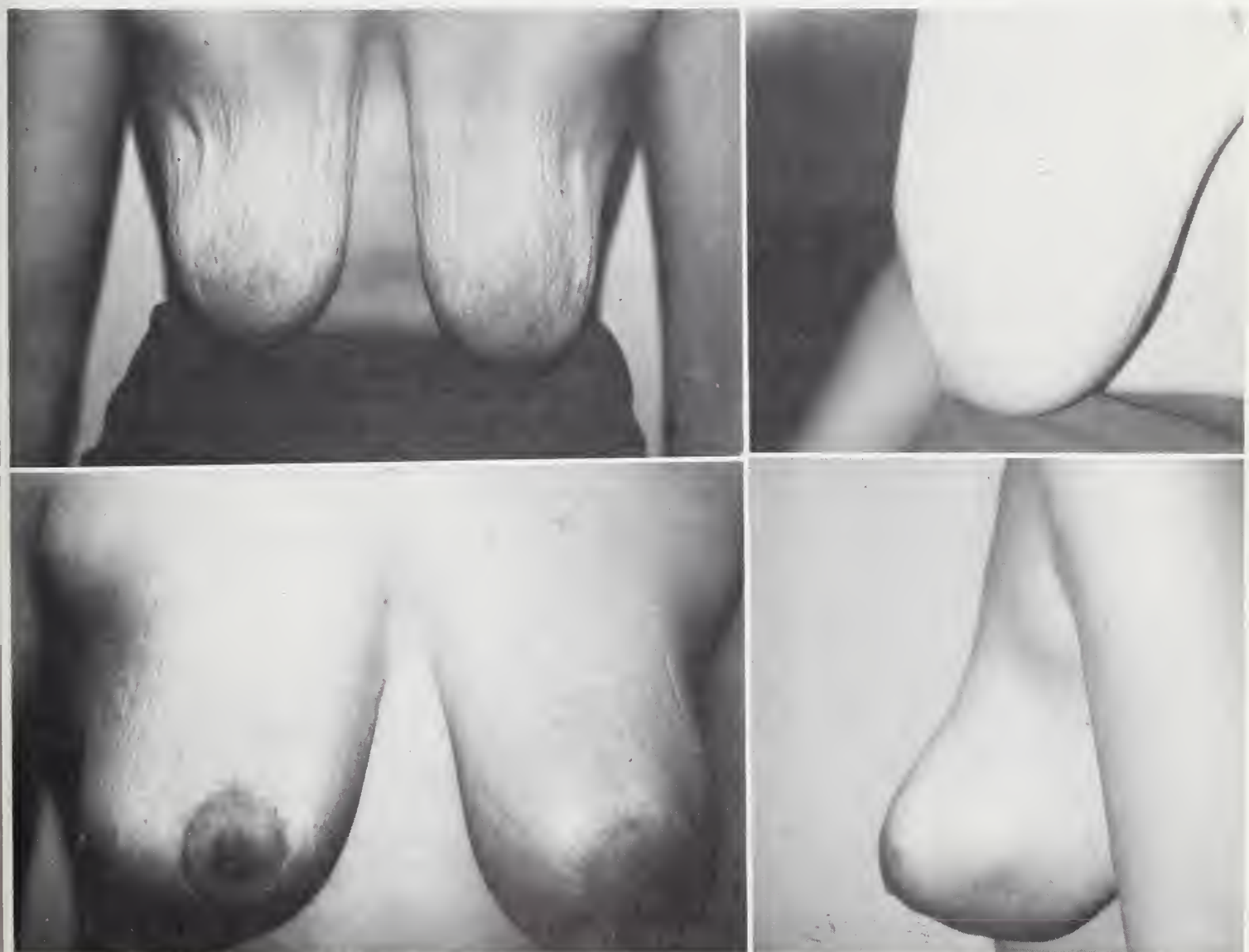


Figure 9. Severe Ptosis of Breasts. A & B (upper) Pre-Operative. C & D (lower) Correction of Ptosis by Modification of Lateral Method.



SUMMARY

The primary aim of a reduction mammoplasty is the relief of the patient's symptoms. Each of the procedures we have discussed does this. But beyond reduction, the surgeon wants to obtain a good cosmetic and functional result with a minimum of disfigurement from scarring. For the reasons outlined, the authors advocate the use of the lateral approach in all but a few extreme cases of macromastia where partial amputation with a free nipple graft is recommended. □

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## OKLAHOMA SURGICAL ASSOCIATION MEETING

Fountainhead Lodge, March 22nd, 23rd, 24th, 1974

All members and other interested physicians are urged to attend this three-day assembly of the Oklahoma Surgical Association to be held at Fountainhead Lodge on Lake Eufaula, March 22nd, 23rd and 24th, 1974.

Two outstanding guest speakers have been named for the meeting. They are United States Senator Henry Bellmon, and Thomas Morse, MD, Chairman of the Pediatric Surgical Outpatient Department of the University of Ohio. The Senator's presentation will be an adjunct to the general scientific program which will emphasize traumatic diagnosis and treatment.

Entertainment has been planned for wives of attending physicians.

Further information regarding reservations and pre-registration may be obtained from the Program Chairman, E. W. Jenkins, MD., 6465 South Yale, Suite 804, Tulsa, Oklahoma 74136, telephone 622-4622. □



# Cephalothin and Cephaloridine: A Re-Evaluation Of *In Vitro* Susceptibilities

WILLIAM HINZ, MD  
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*This paper reports the results of susceptibility tests of more than 1,000 bacterial isolates from clinical specimens to cephalothin and cephaloridine, two new antibiotics.*

Cephalosporin antibiotics have been used extensively for treatment of infections caused by both gram-positive and gram-negative bacteria<sup>16</sup>. A new evaluation of the *in vitro* susceptibilities of various pathogens to cephalothin and cephaloridine was conducted, in order to support the continued selection of these antibiotics for treatment of certain infections. *In vitro* susceptibility tests were performed on 1,146 bacterial cultures that were isolated from clinical specimens over an 8½-month period. Results from the susceptibility studies were analyzed and compared with previous data from this clinic, and with reports from other laboratories.

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Table 1.  
Number of Isolates of Various Bacterial Genera Subjected to *In Vitro* Susceptibility Studies\*

Organism	Number of Isolates
<i>Staphylococcus aureus</i>	199
<i>Staphylococcus epidermidis</i>	62
<i>Enterobacter</i> sp	59
<i>Escherichia coli</i>	324
<i>Klebsiella</i> sp	167
<i>Proteus mirabilis</i>	41
<i>Proteus</i> sp (indole-positive)	30
<i>Pseudomonas</i> sp	171
<i>Shigella</i> sp	26
Miscellaneous	67
Total	1,146

\*Clinical isolates from patients of Children's Memorial Hospital, University of Oklahoma Health Sciences Center from July 1, 1969 to February 15, 1970.

## MATERIALS AND METHODS

**Test organisms.** Bacterial cultures, both gram-positive and gram-negative, used in the study were clinical isolates obtained from July 1, 1969, to February 15, 1970. (Table 1) Initially, all isolated cultures were tested; however, testing after January 1, 1970, was limited to isolates from blood, spinal fluid, urine, feces, and certain cultures from abscesses, wounds and burns.

**MIC determinations.** Minimal inhibitory concentrations (MIC) of cephalothin and



cephaloridine for all bacterial isolates were determined by the broth-dilution microtitration technique of Chitwood.<sup>7</sup> Brain Heart Infusion Broth (BHI-0.025 ml volumes) was the media employed for dilution wells. Dilutions of the antibiotics in log 2 concentrations were made with a heat-sterilized 0.025-ml multimicrodilutor. An inoculum of 0.025 ml of an appropriate dilution from an 18-hr BHI broth culture was pipetted to each well. For the staphylococci, *Enterobacteriaceae*, and pseudomonads, a 10<sup>-3</sup> dilution of the culture was employed, resulting in final inocula sizes of approximately 5 x 10<sup>5</sup> organisms per ml of broth. For fastidious bacteria, such as streptococci, pneumococci, and *Haemophilus* sp, 5% sheep blood was added to the broth, and the inoculum size used was 10-fold larger. Endpoints were determined after overnight incubation at 37°C.

**Disc susceptibility testing.** Disc susceptibility studies were performed using 30-μg discs and the bacterial isolates were streaked on the appropriate media as follows: Oxoid Sensitivity Test Media (Colab) for staphylococci and gram-negative bacilli; blood agar for streptococci and pneumococci, and chocolate agar for *Neisseria* and *Haemophilus influenzae*.

Initially, any zone of inhibition surrounding a disc was interpreted as indicating susceptibility, and conversely, growth without a zone of inhibition was regarded as resistant. More recently, the Bauer-Kirby method with

Mueller-Hinton agar was utilized<sup>2</sup>. Though this method is technically superior, there was no significant change in results observed with these particular isolates, when data from the interpretation of the two methods were compared.

## RESULTS AND DISCUSSION

The *in vitro* susceptibilities of commonly encountered bacteria to cephalothin and cephaloridine, as determined by the disc technique, are presented in Table 2, and by the broth-dilution method in Table 3. Data for less frequently isolated bacteria are shown in Tables 4 and 5.

Nearly all of 277 gram-positive bacteria were judged susceptible to both cephalothin and cephaloridine with the disc susceptibility test. (Tables 2, 4) However, two *S. aureus* cultures and one *Streptococcus* sp (D) required ≥ 12.5 μg/ml of cephalothin for inhibition of growth, when the broth-dilution method was employed. (Tables 3, 4) Group D streptococci are known to exhibit variable susceptibility to cephalosporin antibiotics and the two staphylococcal isolates are possibly resistant to methicillin. Methicillin-resistant *S. aureus* cultures have a heterogeneous population, with the heterogeneity within the total culture population being different for each of the penicillinase-stable penicillins and cephalosporin antibiotics<sup>6</sup>. Regardless of these predictable exceptions, 274 of 277 (≈99%) of the gram-positive bacteria tested were susceptible to the two cephalosporin antibiotics. This current data concurs with the previous findings of Sas-

Table 2.  
Susceptibilities of Various Bacterial Isolates to Cephalothin and Cephaloridine as Determined by the Disc Technique\*

Bacteria	CEPHALOTHIN			CEPHALORIDINE		
	Number of Isolates	Susceptible (%)	Resistant (%)	Number of	Susceptible (%)	Resistant (%)
<i>Staphylococcus aureus</i>	197	99	0	196	100	0
<i>S. epidermidis</i>	61	100	0	61	100	0
<i>Enterobacter</i> sp	55	25	74	57	20	80
<i>Escherichia coli</i>	294	92	7	295	94	6
<i>Klebsiella</i> sp	167	77	28	167	71	29
<i>Proteus mirabilis</i>	43	79	21	43	79	21
<i>Proteus</i> sp (indole-positive)	27	55	45	27	55	45
<i>Pseudomonas</i> sp	167	0	100	168	1	100
<i>Shigella</i> sp	24	92	8	26	100	0

\*See MATERIALS AND METHODS for criteria used to judge bacterial susceptibility to the antibiotics.

The percentages were rounded off to the nearest whole number.



Table 3.  
Susceptibilities of Various Bacterial Isolates to Cephalothin or Cephaloridine  
as Determined by the Broth-Dilution Microtitration Method

Bacteria	Number of Isolates	Antibiotic	Percent susceptible at MIC values* of:						
			0.78	1.56	3.12	6.25	12.5	25	50
<i>Staphylococcus aureus</i>	199	Cephalothin	90	95	98	98	99	99	100
		Cephaloridine	91	94	97	98	100	100	100
<i>S. epidermidis</i>	62	Cephalothin	98	100	100	100	100	100	100
		Cephaloridine	98	98	98	100	100	100	100
<i>Enterobacter</i> sp	59	Cephalothin	0	0	0	2	3	8	14
		Cephaloridine	0	2	3	10	12	30	37
<i>Escherichia coli</i>	324	Cephalothin	1	1	2	5	12	35	69
		Cephaloridine	4	13	29	49	70	83	88
<i>Klebsiella</i> sp	167	Cephalothin	3	4	9	18	28	54	73
		Cephaloridine	1	5	20	37	56	72	83
<i>Proteus mirabilis</i>	41	Cephalothin	0	0	5	39	56	88	93
		Cephaloridine	2	5	7	24	53	73	85
<i>Proteus</i> sp (indole-positive)	30	Cephalothin	0	0	3	13	33	50	50
		Cephaloridine	0	0	0	7	30	57	57
<i>Pseudomonas</i> sp	171	Cephalothin	1	1	1	1	1	1	1
		Cephaloridine	0	0	0	1	4	5	17
<i>Shigella</i> sp	26	Cephalothin	0	0	0	0	0	42	80
		Cephaloridine	4	16	54	88	96	96	100

\*MIC values expressed as micrograms per milliliter of broth.  
The percentages were rounded off to the nearest whole number.

law and Carlisle<sup>18</sup>, Levison *et al*<sup>14</sup>, Hermans *et al*<sup>12</sup>, and Flux *et al*<sup>9, 10</sup>. Thus, as far as gram-positive cocci and *Listeria* sp are concerned, there have been no obvious changes in the susceptibility of these organisms to cephalothin or cephaloridine.

The excellent activities of cephalothin and cephaloridine were recognized by the original investigators<sup>4, 24</sup>. However, these authors also recognized the lower *in vitro* activities of these antibiotics against gram-negative bacilli and the difficulty of testing for susceptibility to cephalothin. Boniece *et al*<sup>4</sup> stated that "gram-negative bacilli are generally much less susceptible to cephalothin than are other organisms, with the exception of certain Group D streptococci." These investigators found that "a relatively light inoculum is required for the detection of gram-negative bacilli sensitive to cephalothin." Later, Wick<sup>22</sup> showed that the acetyl moiety of cephalothin was hydrolyzed during incubation of broth-dilution MIC determination tests. Although this hydrolysis of cephalothin was not obviously important for gram-positive cocci, Wick recommended that tests with usual inocula (10<sup>4</sup>-10<sup>5</sup> bacteria/ml) of gram-negative bacilli should be read after only 12 hr incubation, or a lighter inocula (10<sup>3</sup> organisms/ml) should be employed. Sherris, Rashad, and Lighthart<sup>19</sup> confirmed the increases of cephalothin MIC values when tests

were incubated beyond 12 hr. Ronald and Turk<sup>17</sup> recommended the use of Nutrient Broth when testing acetoxyccephalosporins (cephalothin and cephaloglycin), because hyd-

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rolysis is slower in this medium. On the other hand, Wick and Boniece<sup>24</sup> compared the degree of activity of cephaloridine against gram-positive cocci with that of the penicillins. They also stated that, because of its stability *in vitro*, broth-dilution endpoints could be read after the usual overnight incubation.

For reasons stated above, the comparison of the current MIC values for cephaloridine with those of earlier investigators may be quite accurate. However, because of the variations of test systems, the same data for cephalothin are difficult to evaluate. Since there was no compensation for hydrolysis of cephalothin made in broth-dilution tests used during this current study, criteria for judging susceptibility of gram-negative bacilli to the two antibiotics were established. Gram-negative bacilli with MIC values of  $\leq 25$   $\mu\text{g/ml}$  were considered susceptible to cephaloridine, and  $\leq 50$   $\mu\text{g/ml}$  for cephalothin. These values are not based on the hypothesis that MIC should be below serum concentrations attained with usual dosages of the antibiotics (0.5 gm q.i.d. for cephaloridine and 1.0 gm q.i.d. for cephalothin), but rather on clinical efficacy experienced with permitted doses up to 4 grams daily with cephaloridine and 12 grams daily with cephalothin. The MIC criteria selected thus corresponds with a classification of "intermediately suscept-

ible" to "susceptible" by the "Bauer-Kirby" disc test.

Although 99% of gram-positive bacteria were susceptible to cephalothin and cephaloridine, there are considerable variations in the action of these antibiotics on gram-negative bacteria. Seventy to 100% of isolates of *Escherichia coli*, *Proteus mirabilis*, *Klebsiella pneumoniae*, *Salmonella* sp, *Shigella* sp, *Haemophilus* sp, and *Neisseria* sp are expected to be susceptible to cephalosporin antibiotics<sup>1, 13, 20, 23</sup>. On the other hand, 90% to 100% of *Pseudomonas* sp, *Mima-Herellea* spp, *Proteus* sp (indole-positive), and *Enterobacter* sp are expected to be resistant<sup>23</sup>.

The data presented in Tables 2 through 5 essentially agree with the expected susceptibilities to cephalothin and cephaloridine. Eight isolates of *Neisseria* sp (Table 4) responded similarly to gram-positive bacteria, for all were susceptible to  $\leq 1.56$   $\mu\text{g/ml}$  of both antibiotics; ie, 100%. By the disc test, (Tables 2 and 5) 70% to 100% of *Enterobacteriaceae* [except *Proteus* sp (indole-positive), *Enterobacter* sp and *Mima-Herellea* spp] were susceptible. These percentage values were also within the expected ranges, by the broth-dilution method. Comparisons of data by the two methods for each bacterial genus are discussed below.

Current MIC values for *Pseudomonas* sp agree with data by previous investigators. To cephalothin, 100% were resistant by the disc test (Table 2), and > 98% required > 50  $\mu\text{g/ml}$

Table 4.  
*In Vitro* Susceptibilities of Less Commonly Isolated Gram-Positive Bacteria and *Neisseria* sp. to Cephalothin and Cephaloridine

Bacteria	Antibiotic	Number of Isolates by Disc Test		Number of Isolates Susceptible at MIC of:							
		Suscep- tible	Resis- tant	$\leq 0.78$	1.56	3.12	6.25	12.5	25	50	>50
<i>Diplococcus pneumonia</i>	Cephalothin	9 <sup>a</sup>	0	9		1					
	Cephaloridine	10	0	10							
<i>Streptococcus pyogenes</i> (A)	Cephalothin	4 <sup>a</sup>	0	5							
	Cephaloridine	4	1 <sup>b</sup>	5							
<i>Streptococcus</i> sp (D)	Cephalothin	1 <sup>c</sup>	0							1	
	Cephaloridine	1	0								
<i>Listeria</i> sp	Cephalothin	1	0			1					
	Cephaloridine	1	0			1					
<i>Neisseria meningitidis</i>	Cephalothin	7	0	6	1						
	Cephaloridine	7	0	3	4						
<i>Neisseria gonorrhoeae</i>	Cephalothin	1	0	1							
	Cephaloridine	1	0	1							

<sup>a</sup>One culture of each genus not tested with 30- $\mu\text{g}$  cephalothin disc.

<sup>b</sup>Disc result most likely an error, since MIC values for all cultures were the same.

<sup>c</sup>Disc result most likely an error, since MIC value is high (50  $\mu\text{g/ml}$ ).



Table 5.  
In Vitro Susceptibilities of Less Commonly Isolated Gram-Negative  
Bacilli to Cephalothin and Cephaloridine

Bacteria	Antibiotic	Number of Isolates by Disc Test		Number of Isolates Susceptible at MIC of:							
		Suscep- tible	Resis- tant	≤0.78	1.56	3.12	6.25	12.5	25	50	>50
<i>Alcaligenes faecalis</i>	Cephalothin	2	1						1	1	1
	Cephaloridine	2	1			1	1			1	
<i>Citrobacter freundii</i>	Cephalothin	2	2	1					1		2
	Cephaloridine	1	3			1				1	2
<i>Haemophilis influenzae</i>	Cephalothin	8	0	6			1		1		
	Cephaloridine	8	0	1	1	6					
<i>Herellea</i> sp	Cephalothin	1	4							1	4
	Cephaloridine	1	5			1	1			2	2
<i>Mima polymorpha</i>	Cephalothin	3	6	3			2		1		3
	Cephaloridine	3	6	1		1	2	2		1	2
<i>Salmonella</i> sp	Cephalothin	6	2	1			1		3		3
	Cephaloridine	5	3	2		3	1	1		1	
<i>Providencia</i> group	Cephalothin	1	3						1		3
	Cephaloridine	1	3				1				3

for inhibition (Table 3). The same agreement was not seen for cephaloridine to which 99% were judged resistant by the disc test, but 5.4% (nine isolates) required  $\leq 25$   $\mu\text{g/ml}$  of antibiotic for inhibition. (Tables 2, 3) Growth characteristics of this strictly aerobic genus of bacteria in the micro volumes used for testing may account for this slight variation from other investigators for cephaloridine.

As expected<sup>23</sup>, *Proteus mirabilis* (indole-negative) isolates were more susceptible to both antibiotics, by both disc and broth tests, than any indole-positive *Proteus* sp. (Tables 2, 3) For cephalothin, 79% of the isolates were susceptible by disc and 92.2% by broth test, and for cephaloridine, 79% by disc and 73% by broth. Although  $\leq 50$   $\mu\text{g/ml}$  was used to select cultures susceptible to cephalothin, and  $\leq 25$   $\mu\text{g/ml}$  for cephaloridine, historically, cephalothin is considered slightly more active against *Proteus mirabilis* than cephaloridine<sup>11, 15</sup>. On the other hand, indole-positive *Proteus* sp are usually thought to be highly resistant to the two cephalosporins<sup>11</sup>. The large numbers of these latter cultures reported susceptible in Tables 2 and 3 may be a reflection of the number of times one particular strain was isolated in the same hospital. In-

terestingly, this rather high percentage of indole-positive *Proteus* sp susceptible to cephalothin (Table 2) agreed with 56% of 87 isolates reported from this same hospital in 1963<sup>10</sup>.

More than 70% of *E. coli* isolates are expected to be susceptible to cephalosporin antibiotics<sup>9, 10, 12, 23</sup> and cephaloridine should be slightly more active against members of this genus than cephalothin<sup>15</sup>. By the disc test (Table 2) 92.5% and 93.6% of *E. coli* isolates and by the broth dilution technique 69% and 99% (Table 3) were susceptible to cephalothin and cephaloridine, respectively.

These values are consistent with those reported by Hermans et al<sup>12</sup>, and data from this hospital in 1963 and 1965<sup>9, 10</sup>. Many of the *Escherichia* sp isolated are *E. freundii* (now *Citrobacter freundii*), which is a variant *E. coli*. Data in Table 5 show that *Citrobacter freundii* isolates may be resistant to both cephalothin and cephaloridine.

Most previous reports grouped *Klebsiella* sp and *Enterobacter* sp as *Klebsiella-Aerobacter* spp. This makes the comparison of current and earlier data with these organisms difficult, for *Klebsiella* sp do not produce cephalosporinase



## Cephalothin / HINZ *et al.*

Table 6. Comparison of Current Disc-Susceptibility Data with Previous Studies, Either in the Same Hospital, or from Interpretations by Other Investigators

Bacteria	Cephalothin % Susceptible		Cephaloridine % Susceptible	
	Current	Previous	Current	Previous
<i>Staphylococcus aureus</i>	99	97 <sup>a</sup>	100	97 <sup>b</sup>
<i>Staphylococcus albus</i>	100	98 <sup>a</sup>	100	~100
<i>Diplococcus pneumoniae</i>	100	100 <sup>a</sup>	100	100 <sup>b</sup>
<i>Streptococcus pyogenes</i> (A)	100	100 <sup>a</sup>	100	100 <sup>b</sup>
<i>Streptococcus</i> sp (D)	100	~50 <sup>c</sup>	100	~50 <sup>c</sup>
<i>Listeria</i> sp	100	?	100	?
<i>Alcaligenes faecalis</i>	66	60 <sup>a</sup>	66	0 <sup>b</sup>
<i>Citrobacter freundii</i>	50	~10 <sup>c</sup>	25	~10 <sup>c</sup>
<i>Escherichia coli</i>	92	81 <sup>a</sup>	94	84 <sup>b</sup>
<i>Enterobacter</i> sp	25	~10 <sup>c</sup>	20	~10 <sup>c</sup>
<i>Herellea</i> sp	20	~10	20	~10 <sup>c</sup>
<i>Haemophilus</i> sp	100	~83	100	50 <sup>b</sup>
<i>Klebsiella</i> sp	77	~100 <sup>c</sup>	71	~100 <sup>c</sup>
<i>Neisseria</i> sp	100	100 <sup>a</sup>	100	~100
<i>Mima polymorpha</i>	39	~10 <sup>c</sup>	33	~10 <sup>c</sup>
<i>Proteus mirabilis</i>	79	91 <sup>a</sup>	79	63 <sup>b</sup>
<i>Proteus</i> sp (Indole-Positive)	55	56	55	63 <sup>b</sup>
<i>Providencia</i> sp	25	~10 <sup>c</sup>	25	~10 <sup>c</sup>
<i>Pseudomonas</i> sp	0	11 <sup>a</sup>	1	7
<i>Salmonella</i> sp	75	81 <sup>a</sup>	62	~100 <sup>c</sup>
<i>Shigella</i> sp	92	85	100	~100 <sup>c</sup>

<sup>a</sup> Flux *et al.*, 1964<sup>10</sup>

<sup>b</sup> Flux *et al.*, 1966<sup>9</sup>

<sup>c</sup> Wick, 1969<sup>23</sup>

and *Enterobacter* sp usually do<sup>11</sup>. Also, the "skipped tube" phenomenon for *Klebsiella-Aerobacter* organisms with cephalothin, as reported by Benner *et al.*<sup>3</sup>, could have been because of hydrolysis of cephalothin, or variable rates of  $\beta$ -lactamase production in different tubes. Disc and broth-dilution results in Tables 2 and 3 are in agreement with other investigators<sup>3, 11, 12</sup> in that most *Klebsiella* sp are susceptible and most *Enterobacter* sp are resistant to the two cephalosporin antibiotics tested.

*Shigella* sp isolates presented the greatest difficulty for interpretation, for 92% and 100% were classified as susceptible to cephalothin and cephaloridine, respectively, as determined by the disc test. (Table 2) However, broth dilution MIC values seemed extremely high for these cultures. (Table 3) Slower growth rate of these bacteria, coupled with hydrolysis of cephalothin, may explain the difference in MIC values for the two antibiotics.

Reports on the effectiveness of cephalosporin antibiotics against *Salmonella* sp are variable. Adams and Nelson<sup>1</sup> reported 100% susceptibility *in vitro*; whereas, Steigbigel *et al.*<sup>21</sup> suggested there was poor *in vitro* and *in vivo* correlation. Results in Table 5 also show a wide variation of *in vitro* susceptibility, particularly to cephaloridine.

Data for the remaining less commonly isolated gram-negative bacteria shown in Table 5 are as would be predicted; ie, *Mima polymorpha*, *Herellea* sp, *Alcaligenes fecalis*, and members of the *Providencia* group are mostly resistant. On the other hand, isolates of *Haemophilus* sp are quite susceptible to both cephalothin and cephaloridine.

Comparisons of MIC values with the current study, using serum concentrations attainable with normal dosages of the antibiotics (12.5  $\mu$ g/ml) could lead to false impressions of changes in susceptibility patterns from previous investigators. Branch, Starkey, and Power<sup>5</sup> showed that MIC values obtained by various methods were never the same. Therefore, data from the disc study were used for final evaluation purposes (discussed below).

The *in vitro* susceptibilities of diverse bacterial genera to cephalothin and cephaloridine, as determined by the disc test, are comparable with data from earlier investigators. (Table 6) Sherris, Rashad, and Lighthart<sup>19</sup> stated that when susceptibility tests are properly standardized, the results obtained correlate well with response to therapy in clinical practice. Much emphasis has been placed on standardization of the disc test<sup>8</sup>, and, for this reason, judging changes in susceptibility patterns from previous investigators is probably more valid from data by this method. Therefore, although there are some exceptions, which may be due to the small numbers of isolates of certain organisms, evaluation of the data in Table 6 leads to the conclusion that there have been no significant changes in bacterial susceptibility to these two cephalosporin antibiotics. That is, with good clinical judgment and consideration for safe dosage levels, cephalothin and cephaloridine can continue to be used for therapy of the same types of infections as previously. □

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P.O. Box 26901, Oklahoma City, Oklahoma 73190



## OKLAHOMA MEDICAL SUMMIT

### A Combined Meeting of

The Oklahoma State Medical Association

The Oklahoma City Clinical Society

The Oklahoma Academy of Family Physicians

May 12-15, 1974

AT THE MYRIAD

Oklahoma City, Oklahoma



## Current Status Of The Physician's Assistant In Oklahoma

THOMAS R. GODKINS, PA  
W. D. STANHOPE, PA  
THOMAS N. LYNN, MD

*The American Medical Association has established educational essentials for the Physician's Assistant, approves programs through the Council on Medical Education, and has given full approval to the Oklahoma PA Program which to date, has graduated 19 students.*

Since the inception of the first Physician's Assistant Program at Duke University (1965) and the University of Oklahoma's Physician's Associate Program (1970) there has been a proliferation of programs with a significant variation in caliber, scope, and length of training. The intent of this paper is to briefly review contemporary issues relative to the Physician's Assistant (PA) concept and to discuss the University of Oklahoma's Physician's Associate Program.

The development of this emerging health profession has been plagued with national and international differences in terminology. The national literature is replete with terminology such as Physician's Assistant, Physician's Associate, Medex, Syniatrist, Flexner, Clinical

Associate, and others ad nauseum. These differences in terminology are compounded by invalid comparisons with middle-level medical workers in other countries eg the Feldsher<sup>1</sup> in Russia and the Assistant Medical Officer<sup>2</sup> in the developing nations. In an attempt to resolve the problem of nomenclature the AMA has defined the "assistant to the primary care physician" as a "skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."<sup>3</sup> The National Academy of Sciences' Board on Medicine categorized the PA (Types A, B, & C) according to their scope of training and level of judgment.<sup>4</sup> The National Board of Medical Examiners' (NBME) Special Advisory Committee for the Evaluation of the Assistant to the Primary Care Physician defined the *primary care physician* as one who "accepts responsibility for initial and/or continuing general medical care and health maintenance on a high volume basis . . . are not limited by discipline . . . do not depend on extensive backup services . . . and do not conduct a predominantly referral practice." The NBME Advisory Committee then went on to define the Physician's Assistant as one who "capably performs those functions delegated by and with the supervision of the primary care physician . . ."



TABLE I

## Ultimate Program Objectives

As a condition for graduation each individual must have:

1. Demonstrated personal and intellectual integrity.
2. Demonstrated an empathy and compassion for the patient and his family, and evidence of rapport with colleagues and a variety of individuals.
3. Demonstrated skill in solving clinical problems by:
  - A. Obtaining a history and completing a physical examination.
  - B. Tentative identification of the problem and development of a problem list.
  - C. Gathering more data (physical, laboratory, etc.) as directed by the physician.
4. Demonstrated the ability to:
  - A. Judge his/her own professional capabilities and limitations in any given situation, by doing only what experience permits, asking for help, advice or consultation, following instructions and advice, and accepting responsibility for his/her own errors.
  - B. Diagnose and initiate treatment of a specified spectrum of emergency situations without recourse to immediate supervision, a medical library or text.
  - C. Recognize those conditions that require preventive or therapeutic medical attention, urgent or non-urgent, and those that do not.
  - D. Recognize other allied health personnel as members of the health care "team" and willingly utilize the talents and skills of such personnel.
5. Developed an awareness of basic biologic mechanisms and an appreciation of the scientific approach in developing new knowledge.
6. Achieved the requirements for national certification.
7. Acquired sufficient experience and maturity to recognize the need for self-motivated learning experiences.

There are many reasons for the introduction of the formally trained Physician's Assistant in the United States. There are those who question an absolute physician shortage<sup>5-7</sup> but many concur that at least a "relative" physician shortage exists in many areas.<sup>8-10</sup> The most commonly accepted reasons for the physician shortage lie in an increased demand for physician services,<sup>9,10</sup> a maldistribution of physician manpower,<sup>8</sup> and the increasing number of physicians who specialize.<sup>5</sup> Analysis of the sup-

ply and characteristics of physician manpower in Oklahoma reveal that the total physician to population ratio is approximately 1:990. Also within the state there are tremendous geographical differences regarding physician supply and physician age. For example in Southeastern Oklahoma the physician-to-population ratio is greater than 1:1800.<sup>11</sup> These are some of the reasons attributed to the development of the Physician's Assistant.

Recognizing health manpower needs in the State of Oklahoma, the University of Oklahoma was assisted in the development of the Physician's Associate Program by a Veterans Administration Grant and the Exchange of Medical Information Program based at the VA Hospital in Oklahoma City. The PA Program is administered through the Department of Family Practice and Community Health and is a baccalaureate program. The program developed a fundamental medical curriculum with major input and support from the College of Medicine. The curriculum was designed to give graduates of the program a broad conceptual understanding of medical science in addition to requiring a demonstrated mastery of fundamental clinical skills. It was reasoned that such a conceptual foundation would be necessary to allow the assistant to function effectively in the future when the skills learned in a purely task-oriented program were outmoded.

The PA Program is divided into two phases consisting of a ten-month didactic phase followed by fourteen months of "on the job" clinical practicums. The ultimate objectives of the program are as noted in Table I. The didactic curriculum is noted in Table II which lists each course, specifies the number of class hours attended, and makes special notation of the core courses taken with the medical students. The medical school courses were chosen for their content, the method of instruction; to expose medical students and faculty to this new member of the health care team and, for fiscal reasons. The clinical rotations noted in Table III list nine rotations which provide a balanced mix of inpatient, ambulatory, and emergency health care experience. During the clinical phase of training "primary care" is emphasized by requiring rotations in rural practices. The student is given the opportunity to select preceptors affiliated with the program located in the cities of Chickasha, Enid, Guthrie, Midwest City, Muskogee, Oklahoma City, Shattuck, Stillwater, Stilwell, Tulsa, and Wakita.



TABLE II

## Phase I/Didactic Courses

Course Listings	Hours
*Etiology and Pathogenesis of Disease	216
Behavior Dynamics	54
Anatomy	64
Chemistry	48
Physical Diagnosis and Clinical Medicine	324
*Laboratory Medicine	66
Pediatrics	26
Pathology	52
*Obstetrics/Gynecology	38
**Physiology	126
Nutrition	32
Radiology	16
Pharmacology	48
Parasitology	20
Dental Seminar	18
Dermatology Seminar	18
Emergency Medicine	30
Laboratory Procedures	20
Ethics of Medical Practice and Introduction to Health Care Services	20
Electrocardiography	10
Clinical Medicine Practicums	138
<b>Total Hours</b>	<b>1,384</b>

\*Sophomore Medical School Course

\*\*Freshman Medical School Course

The inpatient experiences are provided at the Veterans Administration Hospitals in Muskogee and Oklahoma City as well as University Hospital in Oklahoma City.

Prior to graduation from the PA Program the student must prove clinical competency through tests evaluating knowledge, ability to collect a complete data base (a complete history and physical examination), technical skills, ability to manage (according to a protocol established by the physician) medical and surgical emergencies, and the interpersonal skills of relating to patients as well as other members of the "health team." These skills are evaluated through traditional pencil and paper examinations complemented by the performance of a complete history and physical examination with oral case presentations to faculty members of the Health Sciences Center.

The program has been inundated with applications from the State of Oklahoma and throughout the country. The program, in its first four years, has had an average of 1,200 inquiries per year, 300 completed applications

TABLE III

## Phase II/Clinical Practicums

6 weeks	Medicine (inpatient)
6 weeks	Medicine (outpatient)
6 weeks	General Surgery
6 weeks	Emergency Medicine
6 weeks	Elective
6 weeks	Elective
6 weeks	Primary Care**
6 weeks	Primary Care**
8 weeks	Preceptorship*
2 weeks	Vacation/Leave
2 weeks	Review & Testing

\* Preceptorship — rotation with a physician of the student's choice or preceptor associated with the PA Program.

\*\* Primary care is defined as a rotation with a physician(s) in the areas of Family Medicine, General Practice, Pediatrics, and/or Obstetrics & Gynecology whereby the physician accepts responsibility for initial and/or continuing general medical care and health maintenance of his patients.

per year, and has accepted 9, 15, 20, and 25 students consecutively. Although two-thirds of the applicants are from out-of-state, preference is given to Oklahoma residents who comprise two-thirds of the present student population. A profile of the first four classes outlining their age, past academic work, and health experience is seen in Table IV.

Postgraduation employment has not been a problem and program graduates are employed throughout the State of Oklahoma in a variety of settings. Each graduate of the program has had an average of four employment offers and Table V reveals the current geographical position of each graduate. Program graduates are employed in solo and group practices, with different levels of responsibility though a typical job description is as seen in Table VI.

Little statistical data is available regarding the acceptance, cost effectiveness, and/or quality of health care rendered by the graduate Physician's Assistants. One study done on acceptance by Pondy, *et al*<sup>12</sup> revealed a curvilinear relationship between patient acceptance increases and educational attainment and income levels. In the experience of the Oklahoma PA Program patient and professional acceptance seems near 100 percent. In the opinion of the authors any study done on patient or professional acceptance, to be valid, is depen-



TABLE IV  
Profile of PA Classes  
(average/years)

	Mean Age	Health Experience (Years)	College Work (Years)
Class '72	32	7.2	3.8
Class '73	29	6.5	4.4
Class '74	28	5.4	3.3
Class '75	28	4.6	4.0
Composite	29	5.9	3.9

dent upon the adequate education of those surveyed regarding the role of the PA. Therefore, the authors believe that the results of most studies done on PA acceptance are of questionable validity. Studies on cost effectiveness and quality of health care rendered by graduate PA's are nonexistent though several PA Programs are currently in the process of evaluating both areas. One study has been done on the quality of health care rendered by PA graduates at the Muskogee Veterans Administration

TABLE V  
Location of Program Graduates

Types of Practice	Town/State	Population* (thousand)	
Class of 1970			
Institutional/ Medicine	OKC	>300	
Primary Care**	Wakita, OK	< 1	
Primary Care	Muskateen, IA	>20	< 30
Orthopedic Surgery	Muskogee, OK	>30	< 40
Institutional/ Neurology	OKC	>300	
Primary Care	Drumright, OK	>1	< 10
Institutional/ Primary Care	OKC	>300	
Class of 1971			
Orthopedic Surgery	Grand Junction, CO	>20	< 30
Primary Care	Guthrie, OK	>1	< 10
Institutional/ Surgery	Muskogee, OK	>20	< 30
Primary Care	Ada, OK	>10	< 20
Primary Care	Granger, IA	<1	
Primary Care	Yale, OK	>1	< 2
Primary Care	Ada, OK	>10	< 20
Primary Care	Sapulpa, OK	>10	< 20
Primary Care	Arkadelphia, AR	>1	< 10
Primary Care	Memphis, TN	>300	
Primary Care	Midwest City, OK	>40	< 50
Primary Care	Stilwell, OK	>1	< 10

\*Based on 1973 Almanac Atlas and Yearbook Statistics.  
\*\*Primary Care as defined in Table III.

Hospital in Oklahoma. Following the addition of five PA's to the staff and utilizing a "medical chart audit" it was concluded that the recorded data base was in all instances as complete and in some cases more complete than had been previously recorded by the physician.<sup>13</sup>

One question often raised is that concerning the liability of the physician in the employment of a Physician's Assistant. The Commission on Medical Practice of the US Department of Health, Education & Welfare has reported on this important issue. Their report, in summary, indicates that: (1) there is a fear by physicians of medical malpractice litigation arising out of the doctrine of "respondeat superior" (the master-servant doctrine); (2) that this has had, however, *no effect* on the employment and utilization of PA's; and (3) that in the opinion of the Commission there is *no* evidence that this fear of litigation is justified.<sup>14</sup>

Many states have passed legislation governing the formally trained Assistant. As of July 1972, 24 states had passed legislation providing for authorization for and control over the Physician's Assistant.<sup>15</sup> Recent unpublished figures released by the American Medical Association reveal that the number of states with legislation allowing for the practice and regulation of the PA is 33. In the State of Oklahoma Senate Bill #506 sponsored by the Oklahoma State Medical Association, became law in April, 1972. This law is representative of a "responsible delegation law" which amends the Medical Practice Act, allows for the regulation of the PA, and in part states:

A Physician's Assistant is a skilled person, qualified by academic and clinical training, who provides patient services and other assistance within the established scope of a physician's practice and under the supervision and responsibility of said physician. The activities of a Physician's Assistant require an understanding of the diagnosis and treatment of disease . . . and a Physician's Assistant must possess a certificate issued by the State Board of Medical Examiners prior to engaging in each occupation . . .

This amendment to the Medical Practice Act delegates authority for the regulation of the PA to the State Board of Medical Examiners. An individual who wishes to practice as a PA in the State of Oklahoma must make application to



TABLE VI

## Sample PA Position Description

**I. Principal Duties and Responsibilities:**

The incumbent must be a graduate of an approved program for Physician's Assistants, and certified by the Oklahoma State Board of Medical Examiners. The incumbent will perform all duties listed below:

**A. Professional**

1. Perform history and physical examinations on new and return patients, both in the office and the hospital, establish presumptive diagnoses, establish the general workup of the patient by ordering appropriate laboratory studies, and be responsible under the physician's supervision for the management of the patient's problem following diagnosis.
2. Perform diagnostic tests such as insulin and IV glucose tolerance tests, gastric analysis, lumbar punctures, and other procedures in consultation and under the supervision of the supervising physician.
3. Perform the following technical tasks:
  - a. Venipuncture and the starting of intravenous therapy
  - b. Arteriopuncture and blood gas analysis
  - c. Application and removal of orthopedic casts and traction apparatus
  - d. Nasogastric intubation
  - e. Nasotracheal intubation
4. Manage medical emergencies such as cardiac arrests, acute respiratory failure, and life endangering traumatic injuries until the arrival of a supervising physician.
5. Assist the physician in planning, organizing, and delivering orderly medical management programs for patients under the physician's care.
6. Make specific nursing home, extended care facility, and home visits under the direction of the physician.
7. Participate in appropriate continuing medical education programs.
8. Assist the physician as directed in the training of health personnel in certain diagnostic, therapeutic, and clinical techniques.

the State Board in conjunction with his/her potential employing physician. The PA's credentials are reviewed, the job description as submitted by the physician is scrutinized, and the application is evaluated by the Board. Included in the regulations are: the stipulation that one physician cannot supervise more than two assistants; that the PA may assist a physician in his/her usual practice of medicine; and that the PA may be utilized in all medical care settings including the office, clinic, hospital, patient's

home, extended care facility, and nursing home.

The AMA in conjunction with appropriate medical specialty societies has developed educational essentials for the assistant to the primary care physician, the urologic assistant, and the orthopedic assistant. Essentials for educational programs for the surgical assistant have been developed by the American College of Surgeons. Programs for the assistant to the primary care physician are approved jointly through the AMA Council on Medical Education and a Joint Review Committee (composed of the specialty societies). The AMA has given full approval to the University of Oklahoma program.

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*Thomas R. Godkins, PA, is a graduate of the Duke University Physician's Associate Program and is currently Associate Director of the University of Oklahoma's Physician's Associate Program. He is the immediate Past-President of the American Academy of Physicians' Assistants. Mr. Godkins serves on many local and national committees concerned with the physician's assistant including the National Board of Medical Examiners Advisory Committee and the Advisory Committee to the State Board of Medical Examiners.*

*William D. Stanhope, PA, is Program Director of the Physician's Associate Program at the University of Oklahoma Health Sciences Center. Mr. Stanhope is a 1969 graduate of the Duke University PA Program. He has been active on many local and national committees regarding the physician's assistant, including the State Board of Medical Examiners Advisory Committee on the Physician's Assistant and the National Board of Medical Examiners Testing Subcommittee on Physician's Assistants. He is a member of an American Hospital Association Advisory Committee established to study the physician's assistant.*

*Thomas N. Lynn, MD, is a graduate of the University of Oklahoma School of Medicine and is currently Medical Director of the University of Oklahoma's Physician's Associate Program. Doctor Lynn is a Professor in the College of Medicine and Chairman of the Department of Family Practice and Community Health at the Health Sciences Center. He is certified by the American Board of Internal Medicine and Preventive Medicine.*



The National Board of Medical Examiners has developed an examination for the Physician's Assistant. This National Board exam will be offered and administered to graduates of: (1) programs approved by the AMA Council on Medical Education, (2) a program that has been funded by the Bureau of Health Manpower Education and (3) a program of at least four months' duration within a nationally accredited school of medicine or nursing that trains pediatric or family nurse practitioners. The first examination was administered on December 12, 1973, and is expected to be available in the spring of 1974 to informally trained physician's assistants who, even though they have not graduated from a formal program, may be able to prove competency. The examination itself has been developed by the NBME with the assistance of an Advisory Committee composed of representatives of the AMA, the medical specialty societies, and Physician's Assistant Program directors, educators, and graduates. It is anticipated that the examination will be widely accepted and that state certifying bodies throughout the country will adopt this examination.

A question of great concern to potential physician employers and hospital administrators is the "insurability" of PA graduates. In Oklahoma the physician can obtain malpractice liability insurance to cover the actions of his assistant. The employed Physician's Assistant can also obtain individual coverage. Nationally, several major insurance underwriters have agreed to provide liability insurance for the PA. The Insurance Company of North

America offers \$100/300,000 to the PA at a cost of \$117 annually when employed by an Oklahoma State Medical Association physician. The OSMA physician may obtain insurance to cover the acts of the assistant for a cost of \$37 annually.

Individuals interested in further exploration of the Physician's Assistant concept and/or the University of Oklahoma's Physician's Associate Program are invited to contact the program office.

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P.O. Box 26901, Oklahoma City, Oklahoma 73190

## AMERICAN BOARD OF FAMILY PRACTICE

### Announces

### Certification Examination

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 19th-20th, 1974. It will be held in five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing: Nicholas J. Pixacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

*Important Note:* It is necessary for each physician desiring to take the examination to file a completed application with the board office. Deadline for receipt of applications in this office is June 15th, 1974. ☐





## News From The Oklahoma State Department of Health

### RABIES PROPHYLAXIS

Since January of this year reports of rabies in animals have been increasing across Oklahoma. Since the potential for human exposure increases with the growth of the animal rabies problem, a few words about rabies prophylaxis are appropriate.

The following recommendations may be modified according to knowledge of the species of the biting animal, circumstances surrounding the bite incident, vaccination status of the animal, and presence of rabies in the region.

Ideally, post exposure rabies prophylaxis should include:

1. Thorough flushing and cleansing into the wound with soap solution. Quaternary ammonium compounds may also be used (remove all soap since soap neutralizes activity of quaternary ammonium compounds);

2. If the biting animal is rabid, has disappeared or is a wild carnivore, antirabies serum is indicated. The recommended dose of antirabies serum is 40 I U/kg (1 vial / 55 pounds). Up to 50% of the antiserum should be used to thoroughly infiltrate the wound and the rest administered intramuscularly. Tests for hypersensitivity *must* be performed;

3. Duck Embryo Rabies Vaccine should then be administered. Twenty-one doses are recommended if antirabies serum is used. Three booster doses of vaccine are also recommended, at 10, 20 and 90 days after the completion of the primary series of 21 doses;

4. All patients should have serum tested for neutralizing antibody three-four weeks after the last booster dose of vaccine;

5. Tetanus prophylaxis and bacterial infection control as indicated.

For consultation and assistance call the Epidemiology Division, 405—271-4060.

#### References:

1. PHS Advisory Committee on Immunization Practices.

2. WHO Expert Committee on Rabies, Sixth Report. □

### COMMUNICABLE DISEASES IN OKLAHOMA FOR JANUARY, 1974

DISEASE	January	January	December	Total To Date	
	1974	1973	1973	1974	1973
Amebiasis	2	1	2	2	1
Brucellosis	—	—	1	—	—
Chickenpox	44	14	14	44	14
Encephalitis, Infectious	3	1	—	3	1
Gonorrhea	739	968	926	739	968
(Use Form ODH-228)					
Hepatitis, A, B, Unspecified	80	35	87	80	35
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	—
Meningococcal Infections	4	2	3	4	2
Meningitis, Aseptic	1	1	4	1	1
Mumps	23	8	44	23	8
Rabies in Animals	8	7	13	8	7
Rheumatic Fever	2	1	—	2	1
Rocky Mountain Spotted Fever	—	—	1	—	—
Rubella	10	2	4	10	2
Rubella, Congenital Syndrome	1	—	—	1	—
Rubeola	3	2	1	3	2
Salmonellosis	13	18	28	13	18
Shigellosis	12	13	18	12	13
Syphilis, Infectious	13	65	20	13	65
(Use Form ODH-228)					
Tetanus	—	—	—	—	—
Tuberculosis, New active	21	22	30	21	22
Tularemia	—	2	—	—	2
Typhoid Fever	—	1	—	—	1
Whooping Cough	1	2	2	1	2



# Oklahoma Medical Summit Scientific Program Growing

The scientific program to be offered during Oklahoma Medical Summit continues to grow. The four-day meeting being held in Oklahoma May 12th-16th will offer outstanding continuing education possibilities.

One of the latest additions to the program will be a special section on "Sudden Unexpected Death" sponsored by the Oklahoma Heart Association. The session will be held Monday afternoon in the Myriad Convention Center. It will be of interest to all Oklahoma physicians.

Lewis Kuller, MD, will speak on the subject "Sudden Unexpected Death — the Identification of Patients and Risk." He is Professor and Chairman of Epidemiology and Microbiology at the University of Pittsburg Graduate School of Public Health and is one of the most active medical investigators in the epidemiologic aspects of sudden death in the United States today. An Oklahoman, C. G. Gerren, MD, Professor of Medicine at the University of Oklahoma Health Sciences Center will present "Sleep, Stress and Sudden Death."

The final presentation during the Sudden Death seminar will be by Leonard A. Cobb, MD, Professor of Medicine at the University of Washington School of Medicine, Seattle, Washington. His presentation is entitled "Clinical Considerations and Prevention of Sudden Death."

Doctor Cobb is director of the Seattle Mobile Intensive Coronary Care project, known as MEDIC-I. This program is cited as a national example since it is designed to have an AID team within three minutes of every home in Seattle, Washington. In addition, he is conducting a continuing study of the long term results of being able to give such immediate therapy.

Another Monday afternoon program during Summit will be presented by the American Cancer Society, Oklahoma Division, on the subject of colon and rectal cancer. James Hartsuck, MD, Director of Surgery at the University of Oklahoma Health Sciences Center, will present "Principles of Colostomy Surgery."

Max Gregory, MD, from the Department of Medicine will present "Fiber-Optic Colonscopy."

Robert Freeark, MD, Director of the Division of Surgery at Cook County Hospital, Chicago, will give two presentations: "Management of Colon Polyps" and "Screening for Colon Cancer." He will be followed by Rupert P. Turnbull, MD, head of the Department of Colon and Rectal Surgery at the Cleveland Clinic in Cleveland, Ohio, presenting "Treatment of Advanced Colon and Rectal Cancer."

Tuesday afternoon the Oklahoma County Unit of the American Cancer Society will sponsor a section on "Endometrial Cancer." Gordon K. Jimerson, MD, Associate Professor in the Department of Gynecology and Obstetrics at the University of Oklahoma Health Sciences Center will present "Review of Histological Changes in Borderline Endometrial Lesions." James A. Merrill, MD, Chairman of the Department, will present "Endometrial Disease in Young People."

"Diagnosis of Endometrial Cancer" will be presented by the Chairman of the Department of Obstetrics and Gynecology at the University of Nebraska Medical Center, Omaha, Robert H. Messer, MD. The Chairman of the Department of Obstetrics and Gynecology at Texas Technological University School of Medicine, Lubbock, Preston W. DeShan, MD, will present "Management of Endometrial Cancer." The final presentation will be "Treatment of Advanced Endometrial Cancer" by Doctor Messer.

The Oklahoma State Health Department will sponsor a Wednesday morning seminar with the catchy title "Everything You Wanted To Know About Venereal Disease." Overviews of the national VD problem and Oklahoma VD problem will be presented by Ralph H. Henderson, MD, with US Public Health Service and Robert L. Bartholomew, Acting Director, of the Oklahoma State Department of Health's Venereal Disease Division, respectively.

"Current Concepts in the Management of Gonorrhea and Syphilis" will be presented by



Michael F. Rein, MD, Assistant to the Chief of Venereal Disease Branch, Bureau of State Services, Center for Disease Control, United States Public Health Service.

Additional scientific programs of interest to all doctors on Monday include a special section on acupuncture in the morning, and on psychiatry in the afternoon. Tuesday will offer a number of options including sections on OB-Gyn, diabetes, the dizzy patient and endocrinology.

Sessions on nephrology, ophthalmology and otolaryngology will round out the options on Wednesday.

All scientific programs, including those offered by the twenty-one allied health groups, will be held in the Myriad Convention Center in Oklahoma City.

While education is important, entertainment is also a big part of Oklahoma Medical Summit. The first social function during the four-day meeting will take place on Sunday evening, May 12th. The entire Gaslight Theater in Oklahoma City has been reserved for physicians and their wives. Dinner and a delightful theater presentation will round out the evening.

Monday will be capped off with a "Keg and Oyster Party" sponsored by Marion Laboratories in the Myriad.

A gourmet banquet on Tuesday evening will round out the entertainment for Oklahoma Medical Summit. To be held in Oklahoma City's beautiful Petroleum Club, atop the Liberty National Tower Building, the banquet will set off a "very brief" inaugural ceremony for the incoming presidents of the three sponsoring organizations of Oklahoma Medical Summit, the Oklahoma Academy of Family Physicians, the Oklahoma City Clinical Society, and the Oklahoma State Medical Association.

Entertainment at the banquet will be furnished by Mr. Mark Russell, an internationally known political satirist and one of the most popular entertainers in Washington, D.C. Russell's songs and sayings about political happenings have made him one of the most "in demand" entertainers of today. In Washington he usually plays to a full house of Congressmen, bureaucrats, diplomats, cabinet members, national newsmen, socialites, and politically aware people. □

## Economic Stabilization Program Regulations For Physicians

In early October of last year the Cost of Living Council proposed new regulations governing increases in medical fees under the Economic Stabilization Program. These new rules, when originally published, were to become effective January 1st of this year. Their implementation was postponed because of a massive reaction from the medical profession.

When finally implemented in early February, the rules were made retroactive to January 1st.

The American Medical Association Center for Health Services Research and Development has prepared a booklet entitled "Physicians Guide to Phase IV" to help physicians in understanding and applying the Cost of Living Council's regulations. The following material was taken from this booklet.

Effective January 1st physicians' fee increases are limited to four per cent on the aggregate weighted price increase for the physician's practice. In addition a ten per cent limit is placed on the price of any individual service or procedure. Fee increases may not result in an increase in the physician's revenue margin.

The only good news seemed to be that physicians could take the increases for which they were eligible under Phases II and III, but which had not yet been taken. These fee increases must be made in accordance with the rules from Phases II and III which require cost justification as an additional restriction. Physicians were eligible for a 2.5% increase in both 1972 and 1973. Cost justification is not required under Phase IV.

Physicians are required to maintain price schedules that are open to public inspection. A sign is to be posted announcing the availability of the schedule.

Under Phase IV there will be no reporting requirements. However, the cost of living council will monitor physician compliance with the rules on a random sample basis. In addition, insurance companies and carriers are "authorized and encouraged" to review a percentage of claims to determine that physicians are conforming to the regulations.

### PRICE INCREASE LIMITATIONS

If a physician wishes to increase his fees, he must show that the fee increases he takes for



various procedures does not exceed a four per cent aggregate fee increase for his entire practice. At the same time he is limited to a ten per cent increase on any individual service or procedure, except for services and procedures under \$10.00 which are limited to a \$1.00 increase.

In order to compute the aggregate weighted price increase that results from each fee increase, the physician must know the percentage of total billings represented by each individual service or procedure being increased. This figure is then multiplied by whatever the percent of increase for the particular service is.

The AMA booklet gives the following example: If a physician wishes to raise his hospital visit charge from \$9.00 to \$10.00, this represents an 11.11% increase. If hospital visits accounted for nine per cent of his total income during the last year, this \$1.00 increase would amount to a one per cent aggregate weighted price increase for this year. This figure is arrived at by multiplying the per cent of price change (11.11%) by the per cent of last year's total billings (nine per cent). Additional such computations would have to be made for each fee increase being proposed, and then the total weighted price change added together to assure that it is no more than 4 per cent.

From the above example one thing becomes obvious: It does not take many \$1.00 fee increases to quickly add up to the four per cent total aggregate weighted price increase limitation.

Any physician increasing his fee should remember the ten per cent individual service increase test for services exceeding \$10.00, and the \$1.00 limitation on increases for services less than \$10.00.

#### ACCUMULATED FEE INCREASES

Physicians who have not taken a fee increase since January 1, 1972, may be eligible for a nine per cent overall increase. Physicians who have not taken a fee increase since January 1, 1973, may be eligible for a 6.5% increase in fees. Generally, physicians are eligible for any unused allowable fee increases not taken under Phases II and III, 2.5% for each.

Physicians who do take a fee increase during Phases II and III may still be eligible for the difference, if any, between their earlier fee increase and the total allowable five per cent increase under Phases II and III.

Before the physician adds any unused allowed fee increase to the four per cent for which he is now eligible, he must cost justify the unused allowable fee increase. To do this he must show that his cost of doing business has increased by a percentage equal to or exceeding the unused allowable percentage fee increase.

The guidelines are specific as to when these costs must have occurred. To be allowable against the 1972 fee increase, the cost must have been incurred between January 1, 1971 and December 31, 1972. In order for costs to be allowable against the 1973 fee increase of 2.5%, the cost must have been incurred during 1973.

All cost increases used to justify the fee increases must be continuous rather than one-time expenses.

Once the physician determines what per cent of increase he is eligible for, then the computation of the unused allowable fee increase may be done exactly as described in the example above, except that the weighted price increase will be higher than the present four per cent limit. Even if it is as high as nine per cent, any single fee can still only increase ten per cent, or \$1.00 for a fee under \$10.00, regardless of the allowable percentage.

#### REVENUE/PROFIT MARGIN LIMITATION

Fee increases are subject to one constraint, they may not result in the increase in the physicians revenue/profit margin in excess of the physicians revenue/margin for his base period. Essentially, the revenue/profit margin is the physicians net income of the practice divided by his gross revenues.

For the computation of his base period revenue/profit margin, the physician may select any two fiscal years ending after August 15th, 1968 other than the fiscal year for which compliance is being measured. Or, if the physician's fiscal year is a calendar year, he may choose any two years from 1968 through 1973.

In his choice of two years to be used in determining a base period revenue/profit margin, the physician should note that a weighted average for the two years is computed. This is not a simple average of the revenue margins for two individual years, but rather a reflection of the aggregate annual revenue and total operating cost differences between the two years.



This weighted average is calculated by computing the two chosen years together to arrive at a revenue/profit margin, instead of computing the years individually and then averaging the revenue margins.

As an example, if a physician chooses two years in which he had a \$50,000 and \$70,000 in gross income respectively and \$30,000 and \$40,000 in profit, he would have a total of \$120,000 in income to divide into a total of \$70,000 profit. This would give him a weighted average revenue/profit margin of 58.33%. This percentage represents the ceiling above which the revenue margin may not increase if his fees are raised.

The interesting thing about revenue margin tests is that they cannot be verified until the end of the fiscal year in which any fee increase takes place. It is up to the physician to estimate his revenues and expenses for the fiscal year to determine if a fee increase is valid even though he cannot verify the validity of his estimate until the end of the fiscal year.

#### PRICE SCHEDULE REQUIREMENTS

The new regulations state that each medical practitioner shall maintain at each facility a schedule showing the customary prices in effect on December 28th, 1973, for those services which comprise 90% of aggregate annual revenues. In addition, this price schedule must show each subsequent change in the price of these services and the date such change in price was made.

Each practitioner must also post a conspicuous and easily readable sign stating the availability and location of the price schedule. The following wording has been recommended for the sign: "To all my patients . . . a schedule of base fees of my principal services and each change in such fees is available in this office upon request, as required by the Price Commission."

It should be noted that prices may not be increased before the sign is posted and the schedule is made available for public inspection. Copies of the schedule must be furnished to any third party payor or the Cost of Living Council upon request.

If any individual fee on the schedule is raised more than four per cent it is necessary for the schedule to also list what percentage of the last

year's total billings that individual fee accounted for.

While the Cost of Living Council has a suggested price schedule form, practitioners may develop their own formats. However, certain identification information must accompany the price schedule. This includes the name, Social Security number or Tax Identification number, and address of the practitioner. In addition, the schedule must also contain on its face the name and title of any individual to be contacted for additional information along with his address and telephone number.

Finally the form must contain a certification and signature by the physician that states, "I certify that the information submitted on and with this form is factually correct, complete and in accordance with Economic Stabilization regulations (Title 6, Code of Federal Regulations) and instructions to Form CLC-82."

#### WAGE AND SALARY INCREASES

Employees in the health care industry, including physicians and employees of professional corporations, are subject to the general wage and salary standards established by the Cost of Living Council. While a number of employees are listed as exempt from the regulations, this does not apply to persons who are employees of acute care hospitals, long term care institutions, health maintenance organizations, medical practitioners or medical laboratories.

Under the new regulations, within a given control year the base compensation rate can only increase up to a maximum of 5.5%. The base compensation rate includes the total remuneration in wages and benefits which the employee receives. Additionally, there is a special allowance of .7% for certain qualified benefits, including health plans, group insurance, pension plans, profit sharing plans, and disability plans. The combined effect of these two limits is equivalent to a 6.2% increase in total remuneration.

The 5.5% standard applies to the total increase in wages and salaries for an "employee unit." An employee unit is a group composed of all employees in a bargaining unit or a recognized employee category. This means that some employees may receive more than 5.5% increases as long as the aggregate increase for the group is not more than 5.5%.

Employees who receive less than \$3.50 an hour are specifically exempt from controls.



In the event that the Cost of Living Council finds that revenue/profit margin limitations and/or price increase limitations have been exceeded, there are a number of remedial actions that may be taken.

As an example, the practitioner may be forced to reduce prices to compensate for the amount by which the limitations were exceeded, or he may be ordered to refund an amount equal to the amount by which the limitations were exceeded.

The regulations state the council may take "any other action which is reasonable and appropriate to cause the remission of such excess prices . . ."

PROHIBITION

One provision in the regulations specifies, "no medical practitioner or medical laboratory subject to this sub-part may adopt any change in charging practices, reduction in quantity or quality of services, or any other practice that has the effect of avoiding compliance with any provision of this title." □

## Nixon Releases Administration National Health Insurance Plan

On February 6th the White House released a statement from President Nixon addressed to the Congress of the United States regarding the administration's National Health Insurance Plan. Earlier the President had alluded to the plan in his State of the Nation speech.

The February 6th document went into more comprehensive detail.

The administration refers to their proposal as a "comprehensive health insurance plan." It has two basic parts, Employee Health Insurance and Assisted Health Insurance.

Under the portion dealing with Employee Health Insurance, known as EHIP, all employers would be required to offer a basic insurance plan and health maintenance organization coverage to each full-time employee under age sixty-five. The coverage would extend to family members of the employee. The employer could choose to self-insure, or purchase the insurance from commercial companies.

The coverage would be voluntary at the option of the employee. Employers would pay 65% of the premium for the first three years of

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the plan, 75% thereafter. Employees would pay the balance of the premiums. A temporary federal subsidy would be available to ease the initial burden on employers who face significant cost increases due to the plan.

Individuals covered by the plan would pay the first \$150.00 in annual medical expenses. A separate \$50.00 deductible provision would apply for outpatient drugs. There would be a maximum of three medical deductibles per family. After satisfying this deductible limit, an enrollee would then pay for 25% of additional bills. The president stated, "However, \$1,500.00 per year would be the absolute dollar limit on any family's medical expenses for covered services in any one year."

Self-employed and non-working families, individuals, and non-employer groups (eg, unions or professional associations), could purchase the plan through private carriers. An employer must offer the basic plan, but could offer optional plans implementing it if they so wish. They could not offer non-approved plans.

The second portion of the comprehensive health insurance plan known as CHIP, is the Assisted Health Insurance Plan, AHIP.

Under AHIP every one not offered coverage under the Employee Health Insurance Plan or Medicare would have available the basic coverage.

AHIP would replace state-run Medicaid for most services. However, states would contract with intermediaries to offer the basic plan to all residents of the state, except those with family incomes with \$7,500.00 or more who are offered the Employee Health Insurance Plan. AHIP is basically the same as the Employee Health Insurance Plan, but is supervised by the individual states.

AHIP would fill many of the gaps in the present health insurance system, according to the President. A principle feature of the plan is that it relates premiums and out of pocket expenses to the income of the person or family enrolled. Working families with income up to \$5,000.00, for instance, would pay no premiums at all. Deductibles, co-insurance, and maximum liability would all be pegged to income levels.

Persons eligible to enroll in AHIP would include families below \$5,000.00 income (\$3,500.00 for individuals) regardless of their

work status, non-working families with incomes of \$5,000.00 to \$7,500.00, and individuals with incomes from \$3,500.00 to \$5,250.00. High risk working families would also be eligible with incomes between \$5,000.00 and \$7,500.00, \$3,500.00-\$5,250.00 for high risk individuals.

Non-working families with unusually high medical risks regardless of income, could be covered by AHIP. This includes the disabled and early retirees. Additionally, the unusually high risk employer groups would also be eligible to enroll in AHIP.

While AHIP would be administered through intermediaries or carriers, any expenditures above the actual premium income would be reimbursed by the state on the basis of actual benefits paid for covered services. The carrier would also be entitled to receive a negotiated fee for administration of the program.

The President outlined the minimum benefit package that he felt would be acceptable under EHIP and AHIP. Reimbursable services would include both hospital and physician services with no dollar limitation. Out of hospital prescription drugs would be included.

Under mental health services, the patient would be entitled to 30 full days or 60 partial days of inpatient care and thirty visits to a comprehensive community care center on an outpatient basis, or fifteen visits to a private practitioner.

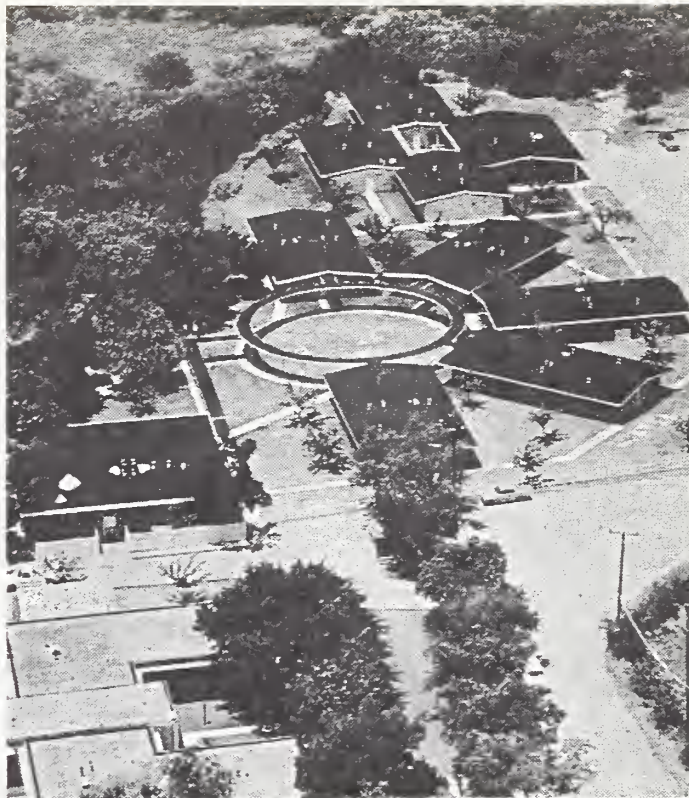
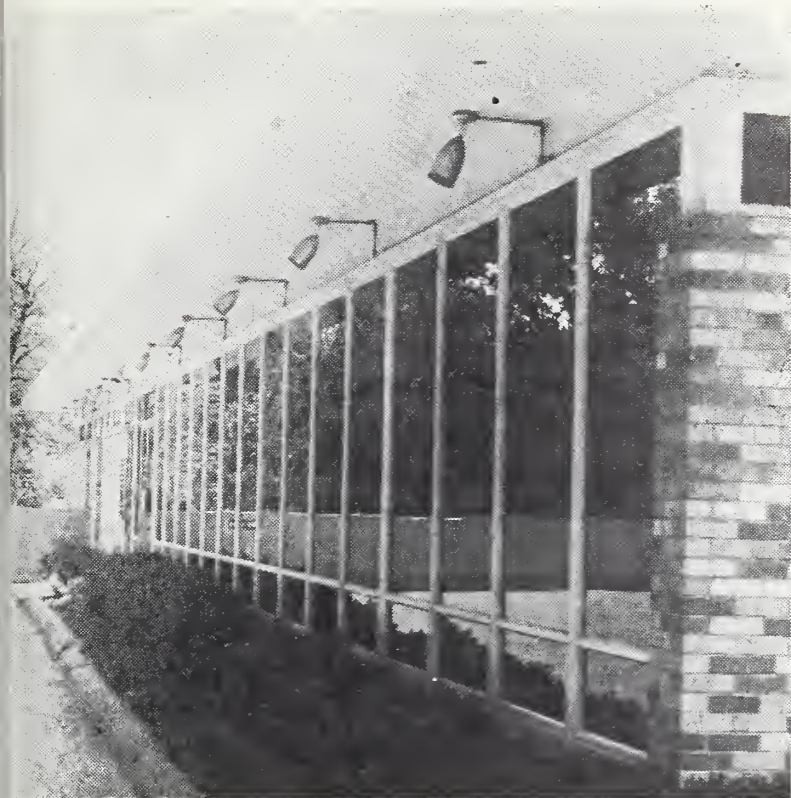
Special and preventative services for children would include well child care up to age six, eye examinations, developmental vision care, and eye glasses up to age thirteen. Ear examinations, hearing aids and routine dental services would be covered up to age thirteen. Pre-natal and maternity services as well as family planning would be provided under the two plans.

Home health services would include one hundred visits per year and one hundred days per year of post-hospital extended care. Blood and blood products would be covered along with other medical services, as in Medicare, including prosthetic devices, dialysis equipment and supplies, x-rays, laboratory, ambulances, etc.

The cost of the Comprehensive Health Insurance Plan was outlined by the President in his February 6th message to Congress. He stated, "When fully effective, the total new cost of CHIP to the federal and state governments

(Continued on Page 116)





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(Continued from Page 114)

would be about \$6.9 billion with an additional small amount for transitional assistance for small and low wage employers . . ." He then went on to say that the federal government would add about \$5.9 billion over the cost of continuing existing programs to finance health care for low income or high risk persons.

State governments would add about \$1 billion dollars over existing Medicaid spending for the same purposes, although these added costs would be largely, if not wholly offset by reduced state and local budgets for direct provision of services.

In explaining what the program would mean to the average American family the President said, ". . . what all these figures reduced to is simply this:

"—The national average family cost for Health Insurance premiums each year under Employees Health Insurance would be about \$150.00; the employer would pay approximately \$450.00 for each employee who participates in the plan.

"—Additional family costs for medical care would vary according to need and use, but in no case would a family have to pay more than \$1,500.00 in any one year for covered services.

"—No additional taxes would be needed to pay for the cost of CHIP. The federal funds needed to pay for this plan would all be drawn from revenues that would be generated by the present tax structure."

The President ended that portion of his message by stating, "I am opposed to any comprehensive health plan that would require new taxes." In referring to health maintenance organizations the President said, "On December 29th, 1973, I signed into law legislation designed to stimulate, through federal aid, the establishment of prepaid comprehensive care organizations. HMOs have proved an effective means for delivering health care and the CHIP plan requires that they be offered as an option for the individual and the family as soon as they become available. This would encourage more freedom of choice for both patients and providers, while fostering diversity in our medical care delivery system."

Congress was also told that the President intended that the services provided under CHIP

would be subject to review by the Professional Standards Review Organizations in each area.

Nixon emphasized the private enterprise approach to his program by stating, "Any insurance company which could offer those benefits would be a potential supplier. Because private employers would have to provide certain basic benefits to their employees, they would have an incentive to seek out the best insurance company proposals and insurance companies would have an incentive to offer their plans at the lowest possible prices. If, on the other hand, the government were to act as the insurer, there would be no competition and little incentive to hold down cost."

CHIP would completely replace Medicaid in each state. However, Medicare would continue to operate much as it has in the past. The Indian Health Service would continue to provide health care for eligible Indians and the Veterans Administration would continue to operate as a separate health care system for those eligible for VA benefits.

The administration plan joins a host of others to be considered by Congress. However, it did contain one surprise for Washington watchers, it was announced that Representative Wilbur D. Mills, Chairman of the powerful House Ways and Means Committee, will be a sponsor of the program in the House.

In concluding his message to Congress, the President said,

". . . Let us not be led to an extreme program that would place the entire health care system under the dominion of social planners in Washington.

"Let us continue to have doctors who work for their patients, not for the federal government. Let us build upon the strength of the medical system we now have, not destroy it.

"Indeed, let us act sensibly. And let us act now—in 1974—to assure all Americans financial access to high quality medical care."

The President's plea for action in 1974 may be of interest to Congressmen, but may not be possible. Representative Mills says that he does not see the possibility of hearings on National Health Insurance until June or July at the earliest. If Congress moves at its usual speed, the final enactment of any National Health Insurance Plan will probably be postponed until sometime in 1975. □



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## Pre-Certification Regulations Stir National Controversy

On January 9th, the Health, Education and Welfare issued proposed regulations that would require pre-certification for elective hospital admissions of Medicare and Medicaid patients. Since pre-certification was a part of the Professional Standards Review Organization's law, many physicians felt that HEW was usurping the rights of any PSRO sponsoring organization.

In a letter to all association members, OSMA President C. Riley Strong, MD, said, "The precipitous federal regulations which were published in the federal register on January 9th completely circumvent the authority granted to private physicians to function under the terms of the PSRO law." He went on to point out that under the law physicians of Oklahoma had an option "until January 1st, 1976, of implementing a Professional Peer Review program which would incorporate a pre-certification feature."

At the present time OSMA's Foundation for Peer Review has undertaken a study of PSRO possibilities for Oklahoma. A report will be issued to the OSMA House of Delegates so that that body may determine whether or not the association will involve itself as a sponsoring agency for PSRO in this state. In the meantime, however, the regulations from HEW were pre-opting any prerogative that the state might have regarding pre-certification.

The January 9th regulations stated that interested organizations had until February 8th to make appropriate comments. A nationwide campaign developed almost spontaneously. It has been calculated that hundreds of Oklahoma physicians wrote the administrator of the Social and Rehabilitative Services Department of HEW and the Commissioner of Social Security objecting to the proposed regulations.

In a letter opposing the implementation of the regulations in the name of the OSMA, President Strong stated, "These regulations are not workable, and they are precipitous from a jurisdictional standpoint. Their implementation at this point will compromise the development of the PSRO program in a very serious way."

The letter pointed out that the regulations would pre-empt the authority granted to PSRO

under Section 249-F of Public Law 92-603. Under this law 182 PSRO's covering all jurisdictions have from January 1st, 1974, until January 1st, 1976, to develop programs applicable to the care of Medicare and Medicaid patients. One feature of that right was the matter of pre-certification of elective admissions for institutional care.

In a strongly worded response, the AMA's president, Russell Roth, MD, stated that the regulations were ". . . wrong medically, wrong morally and wrong legally." He went on to say that the AMA would seek an injunction if the HEW Secretary persisted in implementing the regulations.

After several meetings with medical leaders throughout the United States, HEW's Secretary Casper Weinberger said that he was withdrawing the regulations "with great reluctance." He admitted that the withdrawal of the regulations was due to a strong nationwide protest from physicians.

In telegrams to the various directors of Medicaid programs around the country, Thomas M. Tierney, Director of HEW's Bureau of Health Insurance, said, "the Secretary of HEW has extended for thirty days the period for public comment on the utilization review regulations published . . . January 9th, 1974. In his announcement, the Secretary eliminated the provision for pre-admission certification contained in the proposed regulations. The extension was granted so that further consideration could be given to alternative review procedures that would meet the legal requirements and would be effectively implemented."

The telegram went on to instruct the various Medicaid Directors that they should not implement any provisions of the original regulations until they were published in final form. The original regulations stated that Medicaid plans would be required to adopt the utilization review system considerably more involved than that required by the 1965 Medicare-Medicaid law.

Many medical leaders feel that the entire proposed regulations should have been withdrawn since both the pre-admission and the utilization review portions are in conflict with the PSRO law. By the time this article is published either the regulations on utilization review will have become official, or they will have been withdrawn. The withdrawal could be by legal action or by another nationwide campaign against them. □



## Phase IV Under Legal Attack

Legal action against the Cost of Living Council to remove mandatory wage and price controls on physicians has been undertaken by the AMA's office of General Counsel at the direction of its Board of Trustees. The suit will challenge the validity and protest the discriminatory aspects of Phase IV controls.

The decision to file the lawsuit was announced on February 6th by James H. Simons, MD, AMA Board Chairman, during testimony opposing wage and price controls and the extension of the Economic Stabilization Program before the Senate Sub-Committee on Production and Stabilization.

Earlier before the same committee, John T. Dunlap, Chairman of the Cost of Living Council, presented an administration request that controls in the health field be extended until the enactment of a national health insurance program. (Details of Dunlap's presentation are given on page 120 in this issue of *The Journal*.)

### BOOKLET AVAILABLE

This article on Phase IV was based on a booklet being published by the AMA's Center for Health Services Research and Development. Entitled "Physician's Guide to Phase IV," the booklet is available and may be ordered from the AMA's Chicago office at 535 N. Dearborn Street, Chicago, Illinois, 60610.

On December 26th the AMA had formally protested to Congressman Paul G. Rogers, Chairman of the House of Representatives Sub-Committee on Public Health and Environment, regarding Phase IV discrimination.

By letter to the Congressman, Earnest M. Howard, MD, AMA Executive Vice-President, pointed out, "the objective of Phase II control

was to keep the rate of inflation in the range of two-to-three percent a year. Beginning November 15th, 1971, annual price and wage increases were limited to 2.5% and 5.5% respectively, and these regulations applied to the entire economy. Phase III, which began on January 11th, 1973, and extended to July 12th, 1973, liberated the major portion of the economy from mandatory price controls; *however, physician's fee increases continue to be limited to 2.5%*. This was immediately followed by Phase IV, which brought further relaxation of controls on the remainder of the economy, but continued Phase III regulations on the medical industry."

The Executive Vice-President pointed out that the impact of the Economic Stabilization program on prices throughout the country had met with only mixed success. However, physicians in the United States had demonstrated remarkable restraint in fee increases. He admitted that prior to the Economic Stabilization program physicians fees were rising more rapidly than the all-items component of the consumer price index. During Phase I, the rate increase in physicians' fees was reduced by more than 50%, under Phase II the physicians held fees to an estimated increase of 2.4%. Under Phase III and IV physicians' fees rose only 3.1% while the all-items CPI component rose 6.4%.

While pointing out that physicians' fees are now rising less than one-half as fast as prices in the remainder of the economy, Doctor Howard said, "Despite the excellent record of restraint by physicians in all phases of the Economic Stabilization program, physicians have been singled out for unwarranted harsh regulations. Such regulations have been discriminatorily applied against physicians, beginning with Phase III, and the inequities have been continued in the proposed Phase IV regulations." □

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February 5, 1974

Date

Reagan Bradford  
Administrator



## **Economic Controls Future Outlined By Administration**

An outline of the Nixon administration's proposals for the future of economic controls was given on February 6th before a Senate hearing on the Economic Stabilization Act.

In a statement before the sub-committee on Production and Stabilization of the Senate committee on Banking, Housing and Urban Affairs, the Cost of Living Council Director, John T. Dunlap, urged that the Economic Stabilization Act be amended to continue the Cost of Living Council beyond the expiration date of April 30th, 1974. Specific functions of the council will be to authorize wage and price controls in the health care sector until enactment of health care insurance legislation.

Dunlap also asked that the council be given authority to continue to determine if coverage of any additional sectors by wage and price controls is necessary after April 30th. The extension of the act beyond that date would also allow a gradual de-control on a sector by sector basis without further legislative amendments. It was specified that the council would continue to seek, where appropriate and feasible, "various inflation reducing commitments in exchange for de-control."

Dunlap stated, "while there may be reasonable differences of opinion over the questions whether wage and price controls are necessary in other sectors after April 30th, 1974, the health care area is the only one on which we have reached a conclusion. We shall continue to review particular sectors as the Cost of Living Council proceeds with programs of gradual sectoral de-control."

In recommending that the health care sector continue under control after April 30th, Dunlap pointed out that "it is prudent that the present controls in the health care sector be continued until the Congress can address the important subject of a cost constraint program in national health insurance legislation."

In a press release from the Cost of Living Council regarding Dunlap's testimony before the Senate Committee, no justifications were given for the council's stand on the health care industry.

The news release quoted Dunlap as telling the Senate committee, "Federal government must have a continuing and deep concern with

the rate of inflation. The administration is of the view that the primary reliance should be placed on budgetary and monetary policy and international economic and monetary policy to constrain domestic inflation. Under the conditions anticipated in the year ahead, the problems created by a full program of mandatory wage and price controls outweigh the contribution such controls can make to price stability."

The director made only a passing reference to what many economists feel is the most important single contributing factor to inflation, the activities of the government itself. He said, "there are a series of activities and measures which the government can, and should undertake to contribute to moderation of inflation that do not have the drawbacks of mandatory controls. These activities involve a force within the federal government to see that its own direct impact on prices and wages is less inflationary and to encourage private parties in local and state government to adjust their policies and practices to contribute to a less inflationary economy." □

## **Chiropractic Study May Cost Two Million Dollars**

A little known provision in the HEW appropriations bill that recently passed Congress called for an "independent, unbiased" study of the fundamentals of chiropractic. Congress said, "as much as two million dollars should be earmarked for this study . . ."

In a recent statement by H. Thomas Ballantine, MD, Boston neurosurgeon and Chairman of the AMA's Committee on Quackery, chiropractic was cited as a "threat" to quality health care for the people and its inclusion under Medicare places "in jeopardy the integrity of the entire Medicare—Medicaid program."

Ballantine spoke at the luncheon meeting of the Southeast Regional Conference on Health Quackery — chiropractic, sponsored by the AMA Committee. He pointed out, "probably at no time in the nine years since the Medicare program was enacted has there been what we consider a more serious threat than this to the high quality care called for in the Medicare legislation."

If the Congressional suggestion is followed, the study of chiropractic will be conducted as a



cooperative effort between the National Institute of Neurological Diseases and Stroke and the National Institute of General Medical Science.

In his presentation, Doctor Ballantine posed a series of questions that he said "need to be answered by those who are called upon to administer the chiropractic provisions" added to the Medicare law. Among them:

"Should not the minimum standard for chiropractic participation require, at the very least, that chiropractors be graduates of schools accredited by a nationally recognized educational accrediting agency?

"What is subluxation, (a maladjustment of the spine) as that term is used to define chiropractic services?

"What are the diagnostic standards by which a subluxation shall be deemed to have been shown by current x-ray techniques?

"What pathological conditions of the human body are brought about by a so-called subluxation?

"What evidence is there that manual manipulation of the spine can correct a so-called subluxation and thereby influence favorably a disease process?

"What is a neuro-musculo-skeletal condition, as intended in the published (Medicare) regulations and who is to determine that manual manipulation of the spine is the appropriate treatment?"

Doctor Ballantine closed his presentation by posing the question whether chiropractic qualifies at all under the section of the Medicare law that prohibits payments for items and services "which are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member."

The AMA committee chairman stated that the most unfortunate part of including chiropractic under Medicare would be that it would in effect "guide patients to point of entry health care providers (chiropractors) whose methods of diagnosis and treatment are lacking in scientific validity."

Congress's intent when it authorized the two million dollar research project may have been to determine whether chiropractic does meet the Medicare law requirements of high quality care for the people, according to the Boston neurosurgeon. □

## 1973 "Good Year" For Oklahoma PAC

With 871 members, Oklahoma's Political Action Committee had a good year in 1973. The members contributed nearly \$10,000 to OMPAC and American PAC activities.

OMPAC president, Ed Calhoun, MD, Beaver, said, "I urge all Oklahoma physicians to keep up the good work. In this election year OMPAC needs your monetary support. With one Senate seat and six House of Representative seats up for election, this could be a key year for Oklahoma politics."

AMPAC is predicting that the forces of organized labor will be involved in almost every Congressional District campaign in 1974. In a recent *Across the Boards* publication AMPAC stated, "As never before, organized labor is determined to place its own Congressmen in the U.S. House of Representatives and the U.S. Senate. The Committee on Political Education (COPE) is well on its way toward computerizing the nation's approximately eighteen million men and women affiliated with labor unions, so that in any individual County, Congressional District, or State, COPE can provide political organizers working for its endorsed candidate with a list of all union members, and a good deal of information about those union members (registered, unregistered, Democrat, Republican, etc.)."

COPE itself is being strengthened in an AFL-CIO reorganizational maneuver. W. J. Usery, a highly respected labor mediator, has become the head of the AFL-CIO's new department which has control over field operations, including COPE.

Organized labor is beginning to close ranks after suffering years of strife. Several of the large unions which suspended their affiliation with COPE when the AFL-CIO refused to endorse the 1972 Democratic Presidential candidate have now returned to the fold. Such unions as the American Federation of State, County and Municipal Employees and the Communication Workers of America will be back in COPE in 1974.

This is a major election year in Oklahoma with almost all State offices up for re-election. At the national level, Senator Henry Bellmon and five of the six Congressmen will be up for re-election. Clem McSpadden has announced that he will not run for re-election in the United States Congress, but will run for Governor of the State.



Although most candidates will announce their intentions well in advance, official filing date for offices is July 10th in Oklahoma. The primary election will take place August 27th with the run-off on September 17th. The general election will then be held on the customary day of the first Tuesday in November, which will be November 5th this year.

Registration of new voters and changes of registration will be cut off on August 19th before the primary election; September 9th before the run-off election; and October 28th before the general election.

OMPAC will be 12 years old in 1974, having its beginnings in 1962. In a news letter to all physicians, OMPAC chairman Ed Calhoun states, "OMPAC has consistently supported candidates of both parties who have held the same political and economic views as our members . . . Our track record in candidate support is excellent. In the last election 84% of the candidates we supported won." □

## **US Army Helicopter Ambulance Services Available For Civilians**

Helicopter transportation of sick and injured patients is now available in thirty-two Oklahoma counties courtesy of the United States Army's MAST program. MAST is the acronym for "Military Assistance to Traffic and Safety," an inter-agency arrangement between the departments of Defense, Transportation and Health, Education and Welfare for the rapid movement by helicopter of patients who have suffered injury or sudden illness.

MAST operational area in Oklahoma and Texas is a one hundred mile radius circle around Ft. Sill, near Lawton, Oklahoma, where helicopters to be employed are permanently based.

A "MAST Mission Handbook" has been issued to all hospitals in the thirty-two Oklahoma and eighteen Texas counties inside the circle. The handbook sets out the procedures necessary to call a MAST mission.

The handbook specifies that "a responsible official (hospital administrator or physician) must make the determination that the MAST mission is necessary from a medical standpoint."

Helicopter transportation via MAST can be called on twenty-four hours a day, seven days a week. However, the program should not be used for routine transfers or in cases where transportation could be accomplished as quickly and with no deterioration in the condition of the patient or patients by ground ambulance.

The final authority for all MAST missions rests with the military commander or his designee. Decisions to accept or reject a pilot request are based on aircraft availability, technical considerations, and the impact on the military unit's primary mission.

The handbook, however, points out that the responsible official should not be afraid to call a MAST mission if they feel they have an emergency patient. A serious medical emergency is defined as, ". . . a situation in which an individual's perceived condition requires air transportation to a medical center (or air transportation of medical material or personnel) as quickly as possible in order to prevent his death or the aggravation of his illness or injury, and in which the use of alternative means of transportation will not accomplish that result."

If the military program is utilized, once the patient is in the air, the aircraft commander is in charge of all persons on board the MAST aircraft. One family member may accompany patients, but they are responsible for arranging their own return transportation. The handbook sets out all of the necessary information for calling for a MAST mission, establishing a landing area, marking and lighting the landing area, and preparing the patient and necessary equipment and personnel for MAST transportation.

The primary helicopter to be used by MAST will be the UH-1H "Iriquois" commonly referred to as the "HUEY." It is manufactured by Bell Helicopter Corporation and is one of the most versatile of all military aircraft. It has a range of about one hundred thirty miles out and back, but can travel well over two hundred miles from point to point.

These helicopters are capable of operating from unprepared take-off or landing areas, during instrument conditions, day or night. It is capable of flying forward, backwards, sideways or hover . . . ie, remaining motionless over one spot.

Even though the HUEY is capable of vertical take-offs and landings, these are the least de-



sirable flight conditions. A normal approach and landing with an unobstructed glide path is safest and most desirable.

By special request the aircraft can be equipped with a poised for rescue operations.

The civilian coordinator for MAST in Oklahoma and Texas is H. B. Capozzi. Persons interested in more information on MAST may contact him at the Division of Emergency Medical Services, Oklahoma State Department of Health, N.E. 10th and Stonewall, Oklahoma City, Oklahoma 73105 — Phone (405) 271-4062. □

## **Oklahoma Chapter, American Trauma Society Formed**

Under urging from the national office of the newly created American Trauma Society, the six Oklahoma founding members of the Society have now formed a state chapter. The Oklahoma division of the American Trauma Society has been incorporated and is actively seeking additional founding members who have an interest in emergency medical services.

The six Oklahomans who were actively involved in the founding of the American Trauma Society have been active in emergency medical care in Oklahoma through the Oklahoma Trauma Research Society. The six include five MDs and one layman. The five doctors are D. B. Halverstadt, MD, John A. Schilling, MD, C. Thomas Thompson, MD, Don H. O'Donoghue, MD and E. Ide Smith, MD. The layman is Emery Zarrow.

In a letter to physicians throughout the state the founders of the Oklahoma Division state, "We believe the American Trauma Society . . . has an excellent opportunity of becoming a viable national organization capable of representing all groups interested in the improvement of (emergency medical) services to the American public."

Initially the membership campaign will be conducted for physicians and lay leaders of the various communities. The letter stated, "At a later date, membership will be opened up to others, such as ambulance providers, emergency medical technicians, hospital administrators, etc., with an ultimate membership goal of one thousand or more."

Persons interested in joining the Oklahoma Chapter of the American Trauma Society were asked to contact Mark Morgan at the Oklahoma Trauma Society in Tulsa (918) 663-1577.

Oklahoma is in a unique position in forming a state division of the American Trauma Society, since it has available a staff structure through the presently functional Oklahoma Trauma Research Society. ORTS was actually one of the driving forces behind the creation of the American Trauma Society.

The ATS was formed in 1968 as a voluntary health agency to do for trauma what the cancer and heart associations have done for cancer and heart disease. In a recent address John M. Howard, MD, Secretary-Treasurer of the Society from Chester, Pennsylvania, pointed out that in the eleven years following December of 1961 nearly 46,000 Americans lost their lives in combat in Viet Nam. However, during that same eleven years more than 20 times as many people died of accidents in the United States. The doctor pointed out that it was obviously impossible to eliminate accidents, but if the mortality of accidents could be reduced by as many as five per cent, "We would save more American lives through the next ten years than were lost in the whole long dismal Viet Nam war."

Persons interested in becoming founding members of the society are invited to contribute \$100.00 to the tax-exempt society. Checks should be made payable to the Oklahoma Division—American Trauma Society and sent to 811 Warren Professional Building, 6465 South Yale Avenue, Tulsa, Oklahoma 74136. □

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## **DEATH**

REX M. GRAHAM, MD  
1918-1974

A prominent Miami, Oklahoma general practitioner, Rex M. Graham, MD, died January 20th, 1974 in Miami. A graduate of the University of Oklahoma College of Medicine in 1942, he took his internship at University Hospital in Oklahoma City. In 1943, Doctor Graham established his practice in Miami.

Doctor Graham had been active in civic as well as medical circles and served as secretary-treasurer of the Craig-Delaware-Ottawa Counties Medical Society. □



## Total Health Spending 7.7% of GNP

Health outlays last fiscal year for the nation reached \$94.1 billion, an 11% increase, the lowest rate in several years. The proportion of total health spending to the Gross National Product (GNP) remained at the 1972 level of 7.7%.

Per-capita health expenditures during fiscal 1973 rose \$41.00 to a total of \$441.00, including private and government spending. The Social Security's preliminary figures for the fiscal year that ended last January showed per-capita private spending on health of \$265.00 and government spending of \$176.00 per person for the year.

Private versus public health spending ratio has continued the trend of two decades toward more government spending. The ratio for fiscal 1973 was 60.1% private and 39.9% public. In 1928 the corresponding ratio was 86.7% private and 13.3% public.

Of that \$94 billion total, \$36 billion went for hospital care, \$18 billion for physicians services, compared with \$32.6 billion and \$16.6 billion for the previous year.

Federal spending went up \$2 billion to a total estimated at \$24.5 billion; State and Local expenditures were \$12.9 billion, up more than \$1.5 billion.

A study commissioned by the American Medical Association showed that the average American patient paid about \$209.00 yearly out of his own pocket if he had any medical costs at all. This did not include payments made on the patient's behalf by insurance companies, employers, public agencies or others. Average out of pocket expenditures for those who incurred personal expenses for physician care was \$80.00 during 1970. For hospital care the figure was \$178.00 and prescription medicine was \$52.00.

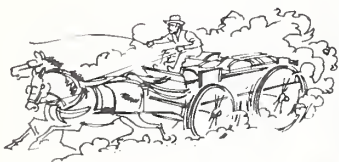
According to the AMA study about 12% of American families had no out-of-pocket costs at all during 1970, while about one-half the population had costs of less than \$100.00. □

## At Your Service in The Sooner State

In the state\* where settlers came "sooner" than the land was opened and two Choctaw Indian words, *okla* meaning *people* and *homa* meaning *red*, gave the state its name . . .



is represented by . . .



Bill Glass



Mike Gorman



Wayne Marlow



Ron Tennissen



Tom White



Jim Woolsey

\*For more information on the history of your state, write Professional Services, Marion Laboratories, Inc.

These men bring you ...





## Changes In Auxiliary Bylaws

Recommendations made at the Mid-Winter Board Meeting for changes in the Bylaws for the Auxiliary. It was done to make them compatible with National as well as to bring them up to date. In the interest of brevity only the NEW wording is given. Please refer to your bylaws.

**"ARTICLE II: Sec. 2 . . .** its program "to improve the quality of life through health education and service."

**ARTICLE V: Sec. 3.** Delete the last sentence; "they shall . . ."

**ARTICLE VIII: Sec. 1.** The President who is in office at the time of the convening of the National Convention shall attend as Presidential Delegate. If she is unable to attend, the President-elect shall attend as Presidential Delegate. In the event that neither is able to attend the National Convention, the Immediate past president shall attend as Presidential Delegate. A portion of expenses shall be allowed for the person attending as Presidential Delegate according to the budget allowance.

**Sec. 2;** The President-elect shall attend the National Convention as an official delegate with a portion of her expenses paid according to the budget allowances. Other delegates shall be appointed by the President in Office at the convening of the National Convention. These shall be named after notification from the National Treasurer of the number allowed for attendance.

**ARTICLE IX: Sec. 2;** . . . Physician's Wife, Co-editor of the Sooner Physician's Wife, . . .

**ARTICLE X: Sec. 5.** Delete present sections e and d.

**Sec. 6;** Add new sec. f, Order the President's

pin. (new lettering for other duties as they now stand e.g. f becomes g; g becomes h)

**Sec. 7;** The Treasurer-elect shall a. Succeed to the Office of Treasurer if the elected Treasurer is unable to serve. b. Serve as an active aid to the Treasurer. c. Be responsible for keeping the addressograph up to date. d. Be a member of the Finance Committee. e. Be a member of The Nurse's Loan Fund committee serving as Recording secretary of this committee.

**Sec. 8, a;** . . . personnel, and send notices of all meetings. d. Editor of the Sooner Physician's Wife edit and publish the Sooner Physician's Wife with the help of the co-editor and such assistance as they may require.

**ARTICLE XI, Sec. 1.** standing committees, chairman of the sub-committees, the counselors . . . .

**ARTICLE XIII** The Trustees of the Oklahoma . . . .

**ARTICLE XV** The official publication of the State Auxiliary shall be *THE SOONER PHYSICIAN'S WIFE*.

**ARTICLE XVI, Sec. 1.** The standing committee and sub-committees of the State Auxiliary shall be A. Finance. B. Bylaws. C. Membership. D. Philanthropy a. AMA-ERF, b. Nurse's Loan Fund. E. Program Development a. State Convention. b. Doctors Day. c. Legislation. F. Health Education and Health Services. a. Safety. b. Mental Health. c. Health Careers. d. International Health. G. Nominating.

In all instances the word **CONSTITUTENT** shall be substituted for the word Component, in referring to auxiliaries." *Mrs. W. M. Leeborn, Chairman; Mrs. J. H. Dunn; Mrs. Harlan Thomas.* □



**A lawsuit demanding that physicians be released from Phase IV controls has been filed by the AMA in the Federal District Court for the District of Columbia. Naming the Cost of Living Council as defendant, the suit asks that the court declare Phase IV regulations to be invalid as applicable to physicians, and invalid as limiting hospital charges and expense reimbursements applicable to inpatients. In its petition the AMA states that Phase IV regulations are "arbitrary and capricious in violation of the requirements of . . . the Economic Stabilization Act . . .". It points out that opticians, psychologists, chiropractors, podiatrists and physiotherapists are all exempt while physicians are still controlled.**

**Citing a statement by John T. Dunlap, Director of the Cost of Living Council, before the Senate Sub-Committee on Production and Stabilization, the AMA alleged that Phase IV control of physicians is political in nature. Dunlap justified Phase IV controls by saying, "It is prudent that the present controls in the health care sector be continued until the Congress has addressed the important subject of a cost restraint program in National Health Insurance Legislation." The petition stated, ". . . to impose controls on physicians' fees and other health care providers, to the exclusion of every other industry other than petroleum constitutes an unwarranted discrimination in violation of the Fifth Amendment to the Constitution."**

**Medicare and Medicaid drug payments may not be limited to the "lowest cost at which the drug is generally available." This "lowest cost" reimbursement plan was announced by HEW Secretary Weinberger some time ago. However, in a recent Senate hearing HEW Assistant Secretary, Charles C. Edwards, MD, substituted the words "a price that permits all reasonable economies" for the more stringent "lowest cost" rule. Just what this bureaucratic word juggling means remains to be seen.**

**Two bills to repeal PSRO are now pending before Congress. HR 9375, introduced last year by Representative John R. Rarick, (D-La.), has twenty-five sponsors. Another bill, recently introduced by Representative Henry B. Gonzalez, (D-Tex.), would repeal PSRO and substitute a provision authorizing the general accounting office to audit hospitals and other health care institutions to determine if Medicare and Medicaid services and fees are unnecessary or excessive.**

**Government medical insurance premiums have doubled since 1965 when Part B of the Medicare Act inaugurated physician bill coverages for \$3.00 per month. Including the current raise of 6.4% annual increases have raised the premium to \$6.70 per month beginning July 1, 1974.**

**Maybe marijuana does cause cellular damage, after all. Investigators from the Columbia University College of Physicians and Surgeons have reported that cellular mediated immunity in fifty-one young chronic marijuana smokers was significantly decreased, and the ability of lymphocytes to undergo cellular division was also decreased forty percent compared to controls. These findings caused the head of the research team to call for a review of the findings of the National Commission on Marijuana.**

**Maybe the energy crisis isn't so bad after all. The National Safety Council says that about one thousand fewer persons were killed in traffic accidents in 1973 than in 1972. The largest part of the reduction came during December when the energy shortages reached their peak for the year. States that had reduced their speed limits experienced a death reduction of twenty-two percent, compared with a reduction of sixteen percent in other states.**

**Physicians' wives are invited to spend a day at the Oklahoma Legislature on April 3rd. State political leaders will speak to the wives during a special session on "The Legislative Process." Speakers will include Governor David Hall, President Pro-Tem of the Senate Jim Hamilton and Speaker of the House, Bill Willis. In addition, party leaders have been invited to discuss the role of the political party in the legislative process. The session is scheduled for the State Capitol in the Supreme Court chambers beginning at 9:30 a.m. □**



## *The Communication Gap In Health Insurance*

As medical costs increase, more and more people are turning to medical insurance to help meet the costs. Doctors' offices are being swamped with additional paper work, delays for payment from insurance companies, and additional misunderstandings with patients as to who must pay.

Although the term has been over used, we found there was a "communication gap" between doctors' offices and insurance companies. Hoping to close this gap, we took a random sampling of insurance companies and medical secretaries. We asked the insurance firms the following questions:

1. What are the most common errors made in the completion of a claim form?
2. What things in particular slow down the processing of claims?

As a whole the insurance companies felt things were running smoothly with only spot problems. However, the major complaint of all companies polled was "not completing the form, leaving things blank." This necessitates a call or a letter to determine if there was no answer to the question or if the information had inadvertently been omitted.

Another big complaint was failure to fully itemize charges, especially laboratory procedures and hospital visits. Most companies wanted not only the panel price for laboratory work, but a breakdown of the tests included in the panel. Some wanted to have an idea of the price of each of the tests included in the panel. They also wanted a listing of dates of hospital visits even if it was follow-up care for surgery.

A note to medical secretaries in large clinics — remember to indicate which doctor gave service; lacking this information seems to slow things down for some companies. Other complaints included failure to cite the entire policy

number . . . those letter prefixes are important. They indicate the type of patient coverage to the insurance company. Some forms are sent in without the patient's signature. Many times admission dates are on the form, but actual discharge dates are omitted. A doctor is likely to be paid more if an operative report is attached for all surgical claims. If there are special circumstances, *ie* night calls, emergencies, complications, an explanation should be attached. This also speeds processing. All of these things add up to a delay of payment of six weeks or more. Many companies received billing on a surgery form from the hospital within ten days. However, they had to wait thirty to sixty days for the doctor's billing. Consensus was they did not want the doctor to wait for final discharge of a patient for a particular illness before submitting an initial claim. Again the major complaint was incomplete forms and inadequate information.

It was only fair that we sample both sides, so we called several doctors' offices and talked to secretaries who handled the insurance matters. Again, we found general satisfaction with the way things were being done. We asked the medical secretaries the following questions:

1. What are your major complaints about insurance forms?
2. What suggestions for improvement would you like to pass on to the insurance companies?

The major complaint arising from the interviews was the form itself. Most secretaries found it confusing and time-consuming to have to "figure out" each company's individual form. They also found that some companies would not accept the standard H I C form. Some forms seemed totally repetitive. Others had billing spaces separated for lab, x-ray, office, and hospital. This meant the secretary had to repeat



the same diagnosis in each space. Another complaint was payment. When a doctor is paid by assignment, the patient is notified of payment by the company itself or in his monthly billing from the doctor. But, if there is no assignment, the doctor never knows what amount was allowed or when the patient was paid.

A major improvement requested by every secretary polled was for a standardized form. They wanted centralized billing spaces with a place for diagnosis. They did not want to search through a chart of a forty-year-old man to determine all the dates he had been treated for tonsillitis in the past. They felt the form should ask questions pertaining only to the current illness being treated.

Many of the complaints from both sides can be eliminated by communication and understanding. A simple "n/a" for "not applicable" can fill a blank space. A simple phone call to an insurance company office can provide answers to questions before the secretary completes the form. We learned a lot just from polling the companies. They seemed more than willing to help with our project and were extremely interested in what the doctors' offices had to say.

One factor has been left out in this discussion, the patient. Good doctor-patient relation-

ships are sometimes ruined by mishandled insurance claims. Be sure the patient completely understands that he is responsible for the bill if the insurance does not pay. Discuss the office policies on insurance with the patient on his first visit. Let the patient know he is responsible for telling the secretary when to bill and for what he wants her to bill. In doubtful cases, such as routine yearly physicals, be sure the patient understands his insurance may not cover the service. Be sure the patient understands that your doctor's bill for surgery does not include the hospital bill or the anesthesiologist's bill. Itemize your billing forms to the patient, and itemize the first time you send out a bill instead of typing a separate bill each time. Always be willing to discuss fees.

We have found that a little more time spent filling out a form *COMPLETELY* the first time, with full explanation and itemization of charges, might mean more payment and faster payment for the doctor.

Remember, communication is the key. ☐

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*Judy Mock, AA, RMA, Instructor, Medical Office Procedures, American College of Health Careers, and Charley E. Stewart, BA, RMS, Instructor, Medical Secretary Program and Director of Placement, American College of Health Careers.*

## TELEPHONE MESSAGE

**While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:**

**232-8115**

**A courtesy message center will be maintained by Southwestern Bell Telephone during Oklahoma Medical Summit in the Myriad Convention Center Exhibit area.**





I just can't write a President's Page without mentioning PSRO. After all, that's about all I have talked about in the President's Page while I have been your president. I feel that Oklahoma has been very effective in getting the

AMA on the ball to do something about PSRO. It is my understanding that very shortly the AMA is coming out with a program of modification and perhaps repeal of PSRO. Because of this controversy, Chairman of the Board Joe Crosthwait and I sent a letter to all AMA Delegates attending the session in Anaheim requesting a return answer on whether or not the intent of the House of Delegates was for repeal. So far, our answers have been overwhelmingly in favor of repeal. I am pleased with our survey.

Both Senator Henry Bellmon and Congressman Clem McSpadden have introduced bills for repeal of PSRO. This makes several bills in Congress to repeal and modify PSRO. Repeal has also been endorsed by Senator Dewey Bartlett, Congressman Happy Camp and Congressman John Jarman. We are seeking a repeal commitment from the balance of the Congressional Delegation from Oklahoma. They have received a four-page letter with arguments against PSRO.

Please look at this issue with all of the interesting information about the Summit meeting. If you miss Mark Russell, you have missed it!

With this President's Page, I am saying farewell to you as your president. Jack Richardson will write the May President's Page. I wish to say that I have enjoyed being your president. I have worked many hours in your behalf and I hope that I have represented you all well.

I do not want to be considered an old man,

but please take note of this poem which I feel should be our collective attitude toward younger physicians, and our mutual goal of trying to preserve the practice of medicine as we have known it in our time.

National Health Insurance, in my opinion, is inevitable.

### The Bridge-BUILDER

An old man going a lone highway  
Came at the evening, cold and gray,  
To a chasm vast and wide and steep,  
With waters roaring cold and deep.  
The old man crossed in the twilight dim,  
The swollen stream had no fears for him;  
But he turned when safe on the other side,  
And built a bridge to span the tide.

"Old man," said a fellow pilgrim near,  
"You are wasting your strength with building here.

Your journey will end with the ending day,  
You never again will pass this way.  
You've crossed the chasm, deep and wide,  
Why build you this bridge at eventide?"

The builder lifted his old gray head.  
"Good friend, in the path I have come," he said,  
"There follows after me today  
A youth whose feet must pass this way.  
The chasm that was as naught to me  
To that fair haired youth may a pitfall be;  
He, too, must cross in the twilight dim—  
Good Friend, I am building this bridge for him."

Will Allen Dromgoole

Fraternally,

*C. Riley Strong MD.*

C. Riley Strong, MD



# Diagnosis of Head and Neck Cancer

RAY SMITH, MD

*Early diagnosis by an alert primary physician offers a head and neck cancer patient the best chance for survival with the least morbidity from therapy.*

Advances in techniques of cancer therapy and in the training of physicians who diagnose and treat cancer offer an improved prognosis for many victims of cancer. Because of the accessibility of the mucosa of the upper respiratory and digestive tracts to examination, tumors of these regions often permit early diagnosis and treatment. The obvious rewards of early diagnosis include increased probability of cure and decreased morbidity from therapy as exemplified by the treatment of laryngeal cancer. Approximately 85% of early carcinomas of the vocal cords can be cured by radiotherapy, thereby permitting the patient to retain his voice; whereas, more advanced laryngeal cancers necessitate laryngectomy after which a lower survival rate is achieved.<sup>1</sup> Because of improved radiotherapeutic and surgical techniques, some patients with large tumors which might appear inoperable can be helped; therefore, patients with seemingly in-

curable cancer should receive consultation from a head and neck oncologist before the prognosis is pronounced hopeless.

The family physician has an opportunity to facilitate early diagnosis and therapy for head and neck cancer patients if he remains alert for signs of cancer and can avoid certain diagnostic pitfalls. The purpose of this paper is to acquaint physicians with the appearance of certain cancers and to provide some guidelines for the management of patients with suspicious symptoms or lesions.

## GENERAL CONSIDERATIONS

The following suggestions are based upon frequently observed problems in the management of cancer patients.

1. *Be Suspicious:* An unidentified lesion of the head and neck deserves a biopsy, a consultation, or both.

2. *Be Tenacious:* As with other clinical tests if a histopathology diagnosis does not agree with your impression, rebiopsy and/or seek consultation. A negative biopsy does not always rule out cancer.

3. *Be Expedient:* Patients generally have wasted all the time that can be devoted to procrastination.

4. *Be Prudent:* If you are not sure of the best diagnostic approach or treatment for your patient seek consultation.

From the Department of Otorhinolaryngology University of Oklahoma Health Sciences Center



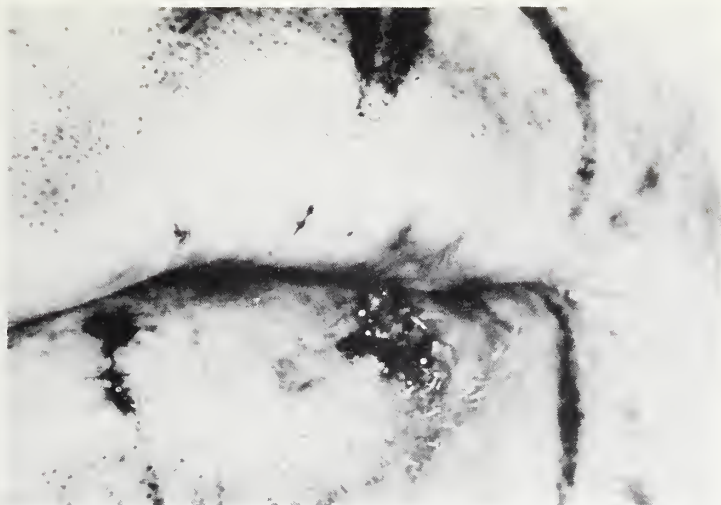


Figure 1. Squamous cell carcinoma of lower lip. Patient complained of non-healing ulcer.

#### SUSCEPTIBLE PATIENTS

Head and neck cancer occurs most commonly in adults over 50 years of age who smoke and/or drink. Oriental males display an increased incidence of nasopharyngeal carcinoma.<sup>2, 3</sup>

#### SPECIFIC REGIONS OF THE HEAD AND NECK ORAL CAVITY

The most common sites for carcinoma of the oral cavity include the lips, the tongue, and the floor of the mouth. Intraoral tumors may be exophytic or ulcerative in appearance, or they may appear superficial and diffuse.

Cancers of the upper lip are usually basal cell carcinomas whereas those of the lower lip most commonly are squamous cell carcinomas. The most frequent clinical appearance is that of a sore which will not stay healed. (Fig 1) A biopsy is easily performed and usually confirms the diagnosis if adequate tissue is submitted to the pathologist.

Patients with anterior tongue neoplasms often have noted a mass on the tongue and have visualized it in the mirror. Anterior

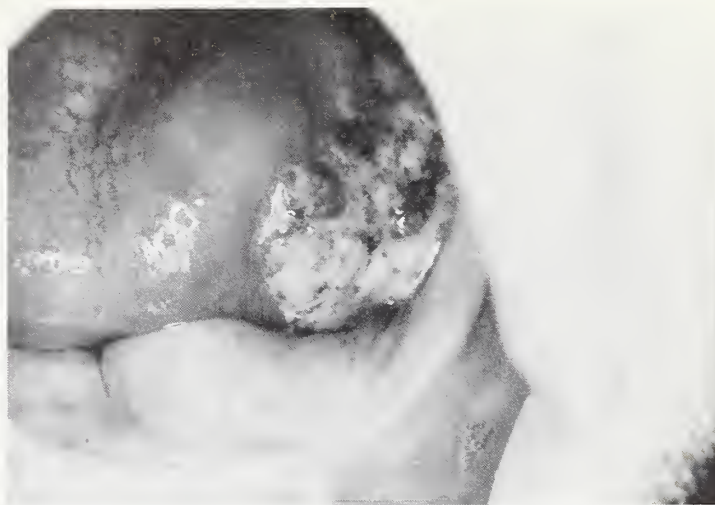


Figure 2. Exophytic carcinoma of anterior tongue.

tongue cancers usually occur on the lateral border of the tongue, examination of which is enhanced by having the patient protrude his tongue and point it toward the opposite side.<sup>4</sup> (Fig 2) Posterior tongue cancers are more occult and frequently escape detection for several months. Patients with large tumors, which even affect speech, may complain only of pain while describing no functional disability. Pain in the base of the tongue or pharynx with referred pain to the ear should alert one to the possibility of cancer.<sup>4</sup> Careful palpation and mirror examination of the base of the tongue assume prime importance in the diagnosis of these tumors.

Examination of the floor of the mouth is facilitated by having the patient elevate the tip of his tongue against his anterior teeth. Ulcerative lesions are particularly apt to be carcinomas. (Fig. 3) Bimanual palpation will frequently confirm the induration associated with a carcinoma.

Tonsillar fossa and palate carcinomas are

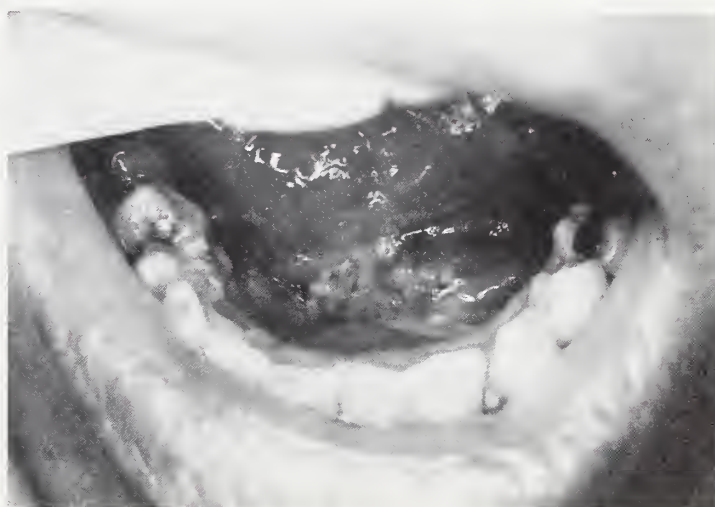


Figure 3. Ulcerating, infiltrating carcinoma of anterior floor of mouth.

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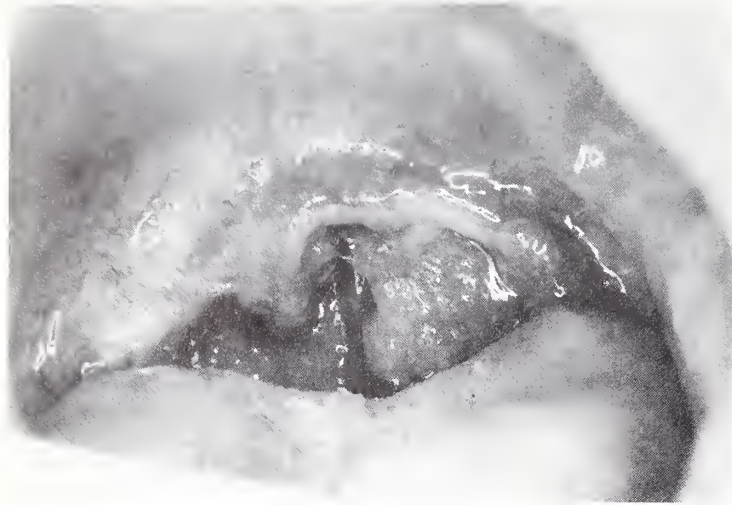


Figure 4. Infiltrating carcinoma of tonsillar fossa and anterior tonsillar pillar.

most commonly ulcerative in appearance. (Fig 4) Palpation may reveal induration; however, most patients tolerate palpation poorly without topical anesthesia.

Inspection of the oral cavity must also include an examination for lesions of the alveolar ridges and buccal mucosa.

Suspect lesions of the oral cavity and lips usually can be biopsied without special equipment. A scalpel, grasping forceps, and some

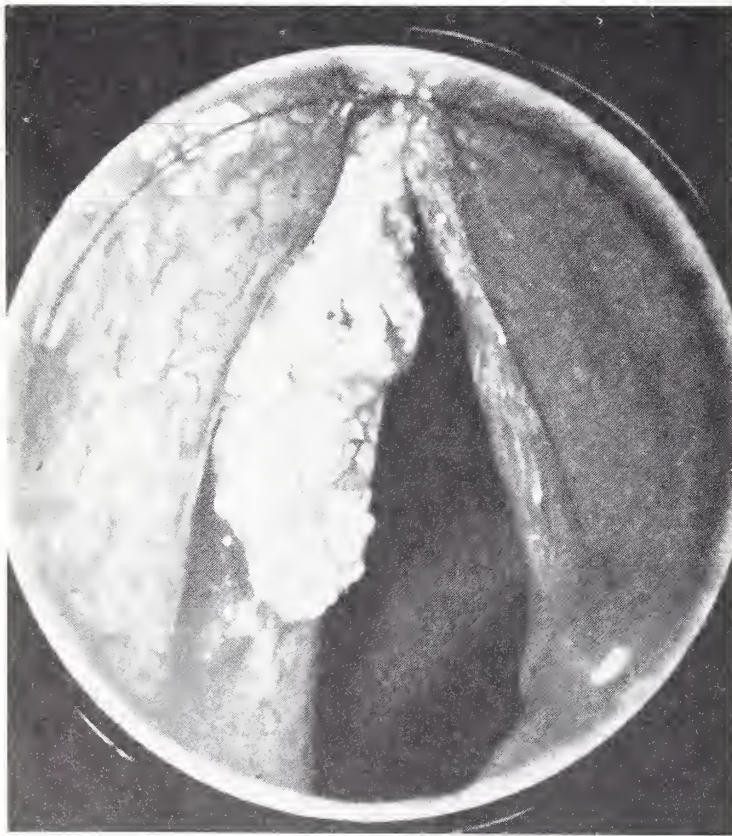


Figure 5. Exophytic carcinoma of vocal cord. Reproduced with permission of Paul H. Holinger, MD and Georg Thieme Verlag. From Becker, W. (Ed): *Atlas of Otorhinolaryngology and Bronchoesophagology*, Stuttgart, Georg Thieme Verlag, 1969, pp. 259.

type of cup forceps usually suffice, and local infiltration anesthesia is adequate for the biopsy procedure. When performing a biopsy the physician should have 3-0 or 2-0 cat gut sutures ready in case of brisk bleeding. Occasionally a small lesion seemingly is totally removed in which case the pathologist may report that the margins of the biopsy specimen are free of tumor. This finding should not lull one into withholding more adequate therapy. Patients with such small lesions can be treated with minimal morbidity and enjoy a high probability of surviving their disease; conversely, a suboptimal resection offers a compromised survival rate for a highly curable lesion.

#### LARYNX

The classical sign of laryngeal cancer is hoarseness, a sign which is usually present in patients with cancer of the vocal cords. (Fig. 5) Unfortunately, cancers within the larynx do not always arise from the vocal cords, and some

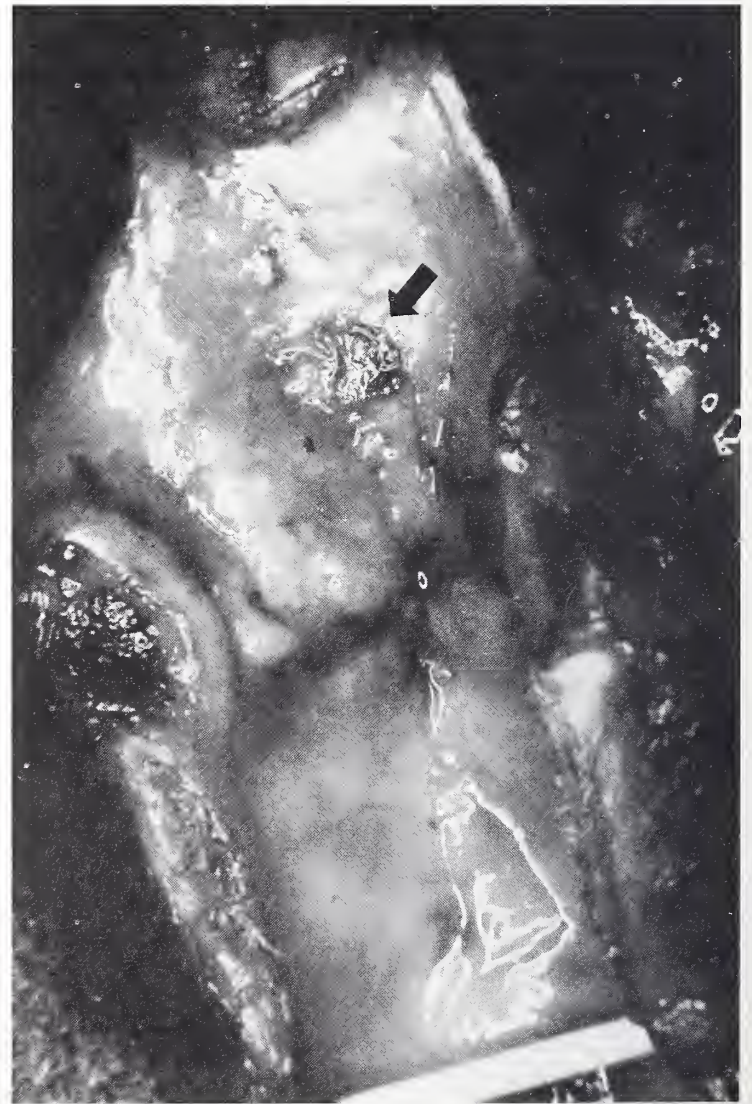


Figure 6. Carcinoma of supraglottic larynx (arrow). Patient complained of pain but was not hoarse.



tumors may grow to fairly large proportions before causing symptoms. Pain and/or dysphasia may be the first symptoms associated with the enlarging mass. (Fig. 6)

Hoarseness which persists for more than two weeks should be investigated. An adequate indirect laryngoscopic examination usually demonstrates the presence of an intralaryngeal tumor; however, opinions vary as to who should perform the examination. Although in the past many practitioners have become proficient in mirror examinations, currently most medical students receive only a brief exposure to otolaryngologic examination techniques. A practitioner who does not feel confident in his own examination should seek early consultation. Those who perform indirect laryngoscopic examinations frequently and proficiently should probably seek consultation if the hoarseness persists for two weeks after the first "negative" indirect laryngoscopic examination since direct laryngoscopy may be required to visualize a lesion. The decision as to whether radiotherapy, limited surgery, or laryngectomy is indicated depends upon subtle variations in the extent of the tumor; therefore, a laryngeal biopsy should be performed by the physician who will plan the definitive therapy.

NOSE AND PARANASAL SINUSES

Patients with intranasal neoplasms usually first notice nasal obstruction or intermittent nasal bleeding. Small paranasal sinus cancers either cause no symptoms or produce a clinical picture which is indistinguishable from chronic sinusitis; therefore these tumors frequently are advanced before the malignant nature of the disease is appreciated. As paranasal

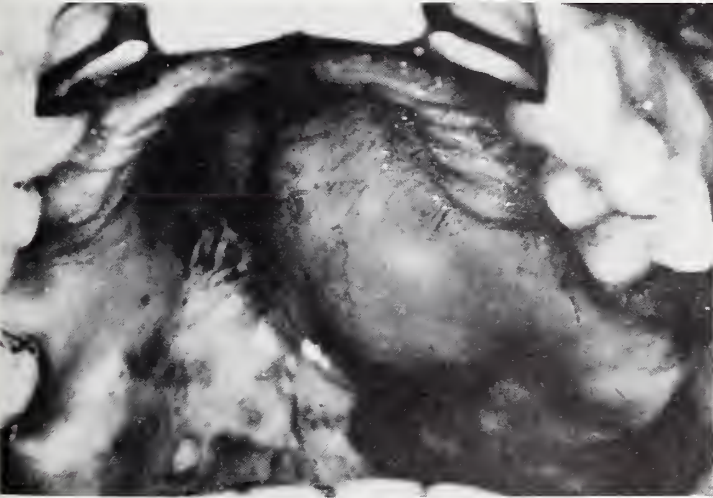


Figure 7. Carcinoma of maxillary sinus pushing hard palate down.



Figure 8. Patient with neuropathies secondary to carcinoma of nasopharynx. Note right abducens palsy and burn of right cheek, which occurred because of hypesthesia of maxillary division of Trigeminal Nerve.

sinus cancers enlarge they either erode into or displace the adjacent nasal cavity, palate, cheek, or eye. (Fig 7) Consultation should be obtained for virtually all suspicious intranasal and paranasal sinus lesions because access to these lesions can be difficult. Bleeding after a biopsy within the nose is a common problem and may be hard to control if one is not experienced in placing nasal packs.

NASOPHARYNX

Nasopharyngeal carcinomas are deceptive tumors that can test the mettle of the most experienced practitioner. Unlike most head and neck cancers, nasopharyngeal carcinomas are not unusual in young males. The author has seen nasopharyngeal carcinomas in two men who were under 30 years of age. Serous otitis media without an obvious cause, nasal



Figure 9. Carcinoma of right pyriform sinus (arrow). Presenting complaint was mass in neck which represented metastasis to cervical lymph node.





Figure 10. Mucoepidermoid carcinoma of parotid gland ulcerating through skin.

obstruction of unknown etiology, or unexplained cranial nerve deficits in an adult should alert one to the possibility of a nasopharyngeal neoplasm. (Fig 8) Examination of the nasopharynx is difficult in most patients, and the diagnostic problem is compounded by the fact that nasopharyngeal carcinomas may be submucosal in extension. Frequently, several biopsies are required before a diagnosis of neoplasm can be confirmed.

#### OROPHARYNX AND HYPOPHARYNX

With the exception of tumors of the base of the tongue, oropharyngeal tumors usually permit inspection with a tongue blade. Tonsillar carcinomas and those of the base of the tongue have been discussed briefly with those of the oral cavity although, anatomically, they are within the oropharynx.

Hypopharyngeal carcinomas frequently escape detection for prolonged periods because, when small, they remain asymptomatic. The pyriform sinuses are the most common sites of origin, and unfortunately, are difficult to visualize. (Fig 9) Persistent pain with referred

pain to the ear or a palpable metastatic node may represent the first clue of a cancer in this location.<sup>5</sup> Compounding the problem of diagnosis is a large number of patients, many of whom are anxious or frankly neurotic, who complain of dysphagia or vague discomfort in the hypopharyngeal region. Despite many fruitless examinations, patients with persisting symptoms deserve a thorough evaluation.

#### SALIVARY GLANDS

Discrete swellings of the parotid gland are usually neoplastic and are usually benign; however 20-25% of parotid neoplasms are malignant.<sup>6,7</sup> Anatomically the parotid gland extends from the zygoma superiorly to two or three centimeters below the mandible inferiorly. Anteriorly the gland extends over the masseter muscle, and posteriorly to the mastoid process. A portion of the gland extends medially behind the mandible, and a tumor of this part of the gland can push the tonsil toward the midline and can be mistaken for an intraoral lesion. Attempted intraoral removal of deep parotid tumors is fraught with danger because of the proximity of the carotid vessels.<sup>8</sup> Lesions which appear to push the tonsil or tonsillar fossa medially should be approached from an external incision by one who is familiar with the complex anatomy of the parapharyngeal space.

At times it is difficult to differentiate a parotid lesion and a lesion of the overlying skin. Generally one can assume a lesion is from a skin appendage if it will slide over the parotid gland with the skin; however, if the skin will slide over the lesion it is probably within the parotid gland and should be treated as such. Tumors which cause facial nerve paralysis or ulceration of the overlying facial skin are almost always malignant. (Fig 10) A parotid gland lesion should only be explored by a surgeon who can readily locate the facial nerve and who is familiar with the biologic behavior of the various histologic types of parotid neoplasms.

Submaxillary salivary gland swellings are usually inflammatory rather than neoplastic; however, approximately 50% of the neoplasms of these glands are malignant and are moderately aggressive tumors. The most common pitfall in the management of a submaxillary neoplasm is for the surgeon to unexpectedly encounter a malignancy and to perform an in-





Figure 11. Recurrence of carcinoma low in neck following radical neck dissection without control of a primary laryngeal carcinoma.

adequate resection. Cure rates for cancer of the submaxillary gland are low (5 year survival = 31%), a fact which emphasizes the attention these neoplasms deserve.<sup>9</sup>

#### NECK MASSES

Physicians are showing an increasing appreciation of the serious implications of a non-tender lateral neck mass in an adult. Most such masses represent metastatic squamous cell carcinoma.<sup>10</sup> In the past, head and neck surgeons frequently saw patients in whom lymph nodes containing metastatic cancer had been removed without an adequate search for the primary tumor. Excision of a suspicious node is a mistake for several reasons:

1. The patient and, rarely, the physician may mistakenly accept the node excision as definitive therapy.<sup>11</sup>

2. The incision for the node removal should be excised at the time of definitive surgery for the tumor, thereby imposing technical problems for the surgeon who performs the procedure.

3. The diagnosis of a tumor within the node invites the more serious error of performing a radical neck dissection without determining the location of the primary tumor. (Fig 11)

4. Definitive therapy is usually delayed by lymph node biopsy.<sup>11</sup>

Even a thorough search by a conscientious physician may not reveal the source of a cancer which metastasizes to the neck. Carcinomas which may evade detection except by endoscopic procedures or random biopsies include those of the nasopharynx, tonsil, base of tongue, pyriform sinus, and esophagus. Careful examination of the scalp will occasionally reveal the source of an unknown primary tumor. Even if the location of a primary tumor which has metastasized to the neck can be determined, the next logical step is consultation with a head and neck oncologist without biopsying the enlarged node. By doing so the primary physician has fulfilled his obligation to the patient by providing the opportunity for optimal care without unnecessary delays or ill advised procedures.

#### SUMMARY

Family physicians have an opportunity to expedite diagnosis and treatment for patients with head and neck cancer. A high level of suspicion, particularly in patients who are most susceptible to cancer, coupled with an awareness of common signs and symptoms of head and neck cancer equip the physician to detect a neoplasm at a time when there is the best chance for survival with the least morbidity from therapy. □

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# Surveillance of Nosocomial Infections in Two Oklahoma City Area Hospitals

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*Baseline data of nosocomial infections are currently being collected from two hospitals in the Oklahoma City area. These data include the distribution of infections by hospital wards, site, types of infectious agents, and possible predisposing factors.*

## INTRODUCTION

Despite the rapid decline of many infectious diseases over the past 25 years, there has been in recent years an ever-increasing awareness of infections related to or acquired within hospitals. Many consider these nosocomial or hospital-acquired infections as one of the more important emerging public health problems<sup>1</sup>. Although much of the data collected throughout the United States are biased and often records are incomplete, general patterns can be demonstrated. In 1970, the average US overall infection rate per hospital was five infections per 100 discharged patients. However, the infection rates ranged from a low of 1.7% in community hospitals to a high of 11.4% in chronic disease hospitals<sup>2</sup>. Although these fig-

ures represent the endemic nature of nosocomial infections, 29 hospital epidemics with a total of 712 cases of infection and 36 deaths were reported over an 18-month period of time<sup>2</sup>.

Since 1970, the Center for Disease Control (CDC) has maintained a national surveillance of hospital-acquired infections from selected hospitals throughout the nation. Although the data differ from one quarter to another, the latest report for the first quarter of 1972<sup>3</sup> indicates a mean overall infection rate of 3.2%. Thus, the endemicity of nosocomial infections apparently has ranged, for all types of hospitals, from 5.0% in 1970 to 3.2% in 1972.

The risk to an individual of acquiring a medical problem other than the one that brought him to the hospital has prompted a surveillance of two hospitals in the Oklahoma City area. The main objective of this surveillance is to collect baseline epidemiologic data in order to determine the endemic and the epidemic levels of infections in these two hospitals. This data will provide useful information and methods for future studies that will include a larger and more representative hospital sample.

A secondary goal, but nonetheless equally important, is to create an awareness among medical and paramedical personnel of the extent and complexities of hospital-associated infections. This in turn should produce the interest necessary to prevent and control these infections.



## METHODS AND PROCEDURES

A nurse epidemiologist made daily rounds in the two selected hospitals. All wards, except psychiatry, were surveyed and investigated for patients who developed a hospital-acquired infection or who showed signs of developing one. A nosocomial infection or hospital-acquired infection<sup>3</sup> was defined as one that occurred in hospitalized patients in whom the infection was not present or known to be incubating at the time of admission. When the incubation period could not be determined, an infection was considered hospital-acquired if it developed at any time after admission. If specimens for laboratory identification had not already been ordered by the attending physician, the nurse epidemiologist alerted him to the case. All microbial identifications were done by the two hospital laboratories and reports were recorded in the patients' records.

Besides the presence of an infection and type of microorganism isolated, other pertinent epidemiologic data were recorded such as geographic distribution of cases by ward, site of infection, possible predisposing factors related to the infection, age and sex of the patient.

Incidence rates were calculated on the basis of two types of numerators: (1) the frequency of cases of hospital-acquired infection and (2) the frequency of episodes of hospital-acquired infections (multiple or subsequent infections). Two main types of denominators were used to represent the population at risk: (1) the number of admissions and (2) patient days in the hospital. The rate using the first denominator indicates the risk to a patient of acquiring a hospital infection once that individual is admitted; the rate using the second denominator measures the risk per day of acquiring a hospital infection.

All information collected by the nurse epidemiologist was coded for IBM punch cards. IBM cards were then punched and verified. Processing of data cards was accomplished with a Wang 720C calculator interfaced with a Univac card reader.

## RESULTS

During the four-month period of observation, a total of 181 cases of hospital-acquired infection was reported by the nurse surveillance officer. The overall attack rate for this time period was 3.96 cases of infection per 100 ad-

missions. The risk to patients of acquiring an infection on a daily basis was found to be 0.54 cases of infection per 100 patient days in the hospital.

The geographic distribution of infected patients within the two hospitals, by ward, may be seen in Table 1. Surgical Service and Children's Service produced the bulk of cases of hospital-acquired infections with 65% of the total. These two areas also represented the two highest case rates of infection: Surgical Service with 4.9 vs 3.8 for Children's Service per 100 admissions.

Multiple infections also occurred among patients admitted to the hospital. (Table 2) For the period under study, a total of 251 multiple infections occurred, representing an attack rate of 5.49 infections per 100 admissions. Another way of observing these data was to examine the daily risk to a patient of

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TABLE I

Cases of Infection in Two Hospitals, by Geographic Location  
Oklahoma City, Oklahoma Area

March—June, 1973

	WARD #	OBS.	DISCHG.	RATE/100 DISCHG.	ADMISS.	RATE/100 ADMISS.	PATIENT DAYS	RATE/100 PAT. DAYS
SURGICAL SERVICE	1	21	399	5.26	401	5.24	2852	0.74
	2	14	494	2.83	507	2.76	3121	0.45
	ICU	23	286	8.04	275	8.36	812	2.83
	TOTAL	58	1179	4.92	1183	4.90	6785	0.85
GYNECOLOGY	1	8	343	2.33	352	2.27	1438	0.56
	TOTAL	8	343	2.33	352	2.27	1438	0.56
MEDICAL SERVICE	1	6	315	1.90	348	1.72	2544	0.24
	2	5	297	1.68	306	1.63	2204	0.23
	3	13	340	3.82	342	3.80	2198	0.59
	CCU	2	107	1.87	111	1.80	332	0.60
	RCU	5	82	6.10	80	6.25	239	2.09
	TOTAL	31	1141	2.72	1187	2.61	7517	0.41
OBSTETRICAL SERVICE	1	20	647	3.09	647	3.09	2874	0.70
	TOTAL	20	647	3.09	647	3.09	2874	0.70
NB-PEDIATRICS SERVICE	1	4	705	0.57	684	0.58	3727	0.11
	TOTAL	4	705	0.57	684	0.58	3727	0.11
CHILDREN'S SERVICE	NSRY	11	174	6.32	184	5.98	1606	0.68
	1	15	341	4.40	351	4.27	1883	0.80
	2	11	324	3.40	296	3.72	2528	0.44
	3	11	335	3.28	323	3.41	1649	0.67
	4	8	198	4.04	201	3.98	1424	0.56
	5	2	171	1.17	192	1.04	1439	0.14
	6	2	60	3.33	53	3.77	507	0.39
	TOTAL	60	1603	3.74	1600	3.75	11036	0.54
HOSPITAL	TOTALS	181	4710	3.84	4575	3.96	33377	0.54

acquiring multiple infections. This risk was found to be 0.75 multiple infections per 100 patient days. As before, Surgical Service and Children's Service provided the higher infection rates, 7.4 and 5.6 multiple infections per 100 admissions, respectively.

As seen in Figure 1, among the microorganisms isolated from patients with hospital-acquired infections, *Escherichia coli*,

*Klebsiella* sp., and *Pseudomonas* sp. constituted 45% of the isolates. The "infamous" *Staphylococcus aureus* made up only 9% of the total isolates. It was of extreme interest that the so-called non-pathogenic *Serratia marcescens* comprised 5% (16 isolations) of the cultures associated with clinical infections in patients.

The sites of initial and subsequent infections



may be seen in Figure 2. Of the various sites implicated, 37% of the hospital-associated infections occurred in the urinary tract. Other sites of infection were surgical wounds (18%), lower respiratory (14%) and primary bacteremia (14%).

Selected therapeutic factors (not mutually exclusive) which might predispose a patient to a hospital-acquired infection were investigated and recorded in Figure 3. These factors were not intended to imply a "causal" role, but to indicate that such factors were present just prior to the onset of infection. Intravenous catheters or cutdowns were identified as present in 83% of the infections and indwelling urinary catheters were present in 55% of the infections. Non-instrument types of factors were also observed. Among the acquired infections, 82% were previously treated with systemic antimicrobial agents for (1) prophylactic measures, (2) the first indication of infection, (3) or during a previous infection prior to admission to the two study hospitals.

Although there was no important disparity in cases of infection, by age-group, the highest proportion (29%) appeared in the older ages, 50-69. The sex distribution of cases of infection

FIGURE I

Percentage Distribution of Hospital-Acquired Microorganisms Isolated from Two Hospitals  
Oklahoma City, Oklahoma Area

March—June, 1973

MICROORGANISMS	
Candida albicans .....	4%
Candida sp. ....	
Citrobacter .....	1%
Diplococcus pneumoniae ..	1%
Enterobacter sp. ....	5%
Escherichia coli .....	19%
Fungi (non-yeast), other	
Hemophilus influenz. ....	
Herrellea—MIMA Group ..	1%
Klebsiella sp. ....	14%
Proteus mirabilis .....	6%
Proteus vulgaris .....	
Proteus sp. ....	2%
Pseudomonas sp. ....	12%
Salmonella sp. ....	
Serratia marcescens .....	5%
Shigella sp. ....	
Staph aureus .....	9%
Staph. epidermidis .....	4%
Strep. alpha hemo. not D ..	3%
Other .....	14%

FIGURE II

Percentage of Initial and Subsequent Hospital-Acquired Infections in Two Hospitals, By Site  
Oklahoma City, Oklahoma Area

March—June, 1973

SITES

Asymptomatic bacteriuria	
Other U. T. I. ....	37%
Upper respiratory .....	5%
Lower respiratory .....	14%
Gastrointestinal .....	
Burns .....	4%
Surgical wounds .....	18%
Other cutaneous .....	3%
Primary bacteremia .....	14%
Other .....	4%

avored the female, 93 cases to 88 for the male. It was of interest that up through age 14, males predominated in the number of cases of infection from 2-4 times that of females, after which the proportion of female cases were higher for most of the remaining age groups.

DISCUSSION

The denominator used in calculating an infection rate should reflect as appropriately as possible a true population at risk. The National Nosocomial Infections Study (NNIS) conducted by CDC uses as its denominator for the calculation of infection rates, the number of discharges to reflect the population at risk. Clearly, the calculated rate could be effected if large numbers of patients are present who were actually at risk, but not discharged until after the termination date. The number in the population at risk may also be estimated by number of admissions rather than discharges. Rates using this denominator were used by the authors in interpretations of results. These two denominators would be approximately the same over a long period if the hospital population were neither increasing nor decreasing and their difference reflects the transient fluctuation in occupancy. Table 1 shows that the use of these different denominators yields a 0.15 difference in rates.

In the calculation of rates by wards the terms "discharges" and "admissions" must be interpreted relative to each ward, ie a transfer from a ward is counted as a discharge for that ward and transfer into a ward is counted as an admission. Thus, a sum of the column of dis-



FIGURE III

Percentage of Possible Predisposing Therapeutic Factors Associated with Hospital-Acquired Infections in Two Hospitals—Oklahoma City, Oklahoma Area

March—June, 1973

PREDISPOSING FACTORS

Indwelling Urinary Cath. ....	55%
Non-indwelling Urinary Cath. ....	6%
Other Urinary Instrumentation ....	10%
Tracheostomy ....	4%
Pos. Pressure Resp. Assist. ....	49%
I. V. Cath. or Cutdown ....	83%
Pre. Systemic Antimicrob ....	82%
Radiation Therapy ....	8%
Cytotoxic Therapy ....	9%
Systemic Adrenal Steroids ....	13%
Arterial Instru. ....	6%
Wound Foreign Body .....	
Bronchoscopy .....	
Supra-pubic Bladder Cath. ....	2%
Dialysis ....	1%
I. V. Hyperaliment. ....	10%
Other .....	2%

charges or admissions by wards does not yield the number of discharges or admissions for the hospital total. In addition, another rate was utilized that would estimate the risk of

hospital-acquired infections *per patient days*. This would depict the risk of acquiring an infection for every day of hospital confinement.

The question arises as to whether the rate using patient-days as a denominator or the rate using an estimate of the number of people at risk as a denominator is the better indicator. The problem lies in the fact that the two rates cannot be compared because not only do they measure different risks, but the size of the denominators is drastically different. Since patient-days are an accumulation of the number of days exposed in a hospital by each patient, a much larger number is observed in the denominator as compared to the number of admissions; although the frequency of infections (numerator) is identical for each rate. Thus, a much smaller rate is calculated for patient-days than that based on admissions. Therefore, the answer as to which denominator is preferable depends entirely on what one is interested in measuring. The patient-day rate would have a procedural advantage in surveillance studies within a given hospital (intra-hospital) in that the sum of patient-days over all wards is the patient-days appropriate for the total hospital rate. Also, this rate inherently adjusts, to some extent, for ward-to-ward discrepancies in duration of confinement.

It is extremely important that when observing infection rates in the literature for a particular hospital or group of hospitals, that one be cognizant of the population at risk used in the calculation of those rates.

Infection rates were calculated based on discharges in order to compare our data with that of NNIS, which does not use admission or patient-day information.

Higher rates of infection (multiple infections) were found in this study when compared to those found by NNIS over a similar period for 1972. Although the time periods did not exactly correspond, data for the months of April, May, and June, 1972 did correspond to three of the four months in this study. The median infection rates for similar type hospitals for April, May, and June 1972 for NNIS were 3.0, 3.5 and 4.4 infections per 100 hospital discharges, respectively, as compared to our infection rates for the same months in 1973 of 5.5, 5.8 and 6.0 per 100 discharges, respectively. Our infection rate of *persons* having at least one nosocomial infection could not be compared to NNIS since they use only episodes-of-infections and not incidence-of-persons with an infection.



TABLE II

Infection Rates in Two Hospitals, by Geographic Location  
Oklahoma City, Oklahoma Area

March—June, 1973

	WARD #	OBS.	DISCHG.	RATE/100 DISCHG.	ADMISS.	RATE/100 ADMISS.	PATIENT DAYS	RATE/100 PAT. DAYS
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	2	17	494	3.44	507	3.35	3121	0.54
	ICU	39	286	13.64	275	14.18	812	4.80
	TOTAL	88	1179	7.46	1183	7.44	6785	1.30
GYNECOLOGY	1	8	343	2.33	352	2.27	1438	0.56
	TOTAL	8	343	2.33	352	2.27	1438	0.56
MEDICAL SERVICE	1	6	315	1.90	348	1.72	2544	0.24
	2	5	297	1.68	306	1.63	2204	0.23
	3	17	340	5.00	342	4.97	2198	0.77
	CCU	2	107	1.87	111	1.80	332	0.60
	RCU	5	82	6.10	80	6.25	239	2.09
	TOTAL	35	1141	3.07	1187	2.95	7517	0.47
OBSTETRICAL SERVICE	1	25	647	3.86	647	3.86	2874	0.87
	TOTAL	25	647	3.86	647	3.86	2874	0.87
NB-PEDIATRICS SERVICE	1	5	705	0.71	684	0.73	3727	0.13
	TOTAL	5	705	0.71	684	0.73	3727	0.13
CHILDREN'S SERVICE	NSRY	16	174	9.20	184	8.70	1606	1.00
	1	24	341	7.04	351	6.84	1883	1.27
	2	23	324	7.10	296	7.77	2528	0.91
	3	14	335	4.18	323	4.33	1649	0.85
	4	9	198	4.55	201	4.48	1424	0.63
	5	2	171	1.17	192	1.04	1439	0.14
	6	2	60	3.33	53	3.77	507	0.39
	TOTAL	90	1603	5.61	1600	5.63	11036	0.82
HOSPITAL	TOTALS	251	4710	5.33	4575	5.49	33377	0.75

The higher incidence of patients with hospital-acquired infections in the surgical and children's areas was not surprising. Surgical patients are at greater risk of infection than those in other units due to the added hazard imposed by surgical trauma. The very young are at higher risk of infection because of the lack of a well-developed defense system against microbial invasion.

Although data were collected on selected therapeutic factors which could predispose a

patient to a hospital-acquired infection, no definitive conclusions can be drawn. Surveys such as this are designed to obtain clues or hints for later, more sophisticated studies. Thus, several factors were identified as "possibilities:" intravenous catheters or cutdowns, urinary catheters, positive pressure respiratory assistance, systemic glucocorticosteroids and previous treatment with antimicrobial agents. However, validity of these findings is possible only when an infected group is com-



pared to an uninfected group in regard to similar instrumentations and procedures.

The types of infectious agents isolated in the survey are similar to those isolated by NNIS, but in different proportions. Apparently, *Serratia* appears as frequently in nosocomial infections as do the classic pathogens. This points out the fact that in a hospital setting, the debilitated patient may influence the infectious process to a greater extent than the virulence of the agent alone.

Over one-half of all infections occurred in the urinary tract and surgical wounds. There may be some correlation between urinary tract infection and the high percentage (65%) of infections in which indwelling urinary catheters and other urinary tract instrumentations were present just prior to onset of infection. However, valid conclusions will have to wait for future studies in which case-control methods can be employed to determine statistical associations.

Although there were some differences in the age and sex distributions of hospital-acquired infections, one must consider that the observed data were merely frequencies and not rates. Since data on the ages and sex of uninfected persons were not collected, it was impossible to calculate meaningful rates. Thus, any conclusions as to age and sex must wait for the collection of more data.

Since this survey is a continuing study, monthly reports are generated in order to inform hospital personnel of changes that occur in baseline data. Significant deviation could alert the hospital staff to a possible epidemic. It is hoped that when funds become available a similar monitoring of other hospitals in the city could be accomplished.

#### SUMMARY

A continuing surveillance of two hospitals in the Oklahoma City area was undertaken to determine the incidence of hospital-acquired infections, by geographic location, sites infected, types of infectious agents, possible predisposing factors and demographic data. This report covers a four-month period.

An overall rate of persons acquiring a hospital infection was 3.96 per 100 admissions. The risk of multiple hospital-acquired infections for the same four-month period was 5.49 per 100

admissions. Rates based on discharges and patient-days were also calculated, and the denominator of choice used to represent the risk population was discussed.

Surgical and children's areas accounted for the highest incidence of patients with nosocomial infections (4.9 and 3.8 infected patients per 100 admissions). Similarly, the highest rates of multiple infections (7.4 vs 5.6 infections per 100 admissions) were also observed within these two services.

The urinary tract and surgical wounds were the sites in which over one-half of all hospital-acquired infections were isolated. *Escherichia coli*, *Klebsiella sp.*, and *Pseudomonas sp.* constituted 45% of all microbial isolations. The normally non-pathogenic *Serratia marcescens* comprised 5% of the total isolations from hospital-acquired infections.

Although "causal" relationships cannot be established, intravenous catheters or cutdowns and indwelling urinary catheters were present more frequently just prior to onset of infection than any other type of instrument examined. Among non-instruments, systemic antimicrobial agents were administered for various reasons in 82% of the hospital-acquired infections. Case-control studies would have to be done before valid associations could be made. No important disparities were observed for either age or sex.

Data such as these are important to collect for all hospitals to determine baseline or endemic levels of infections. Epidemic situations would therefore be evident when the level of new infections rises above and beyond the endemic level. Also, the monitoring of types of microbial agents isolated from infections would help to identify changes in hospital bacterial flora. □

#### ACKNOWLEDGEMENT

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Note: All tables and figures are replicas of the original Wang 720C print-outs.

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# Therapy With Amphotericin B and Other New Antifungal Agents

HARRIS D. RILEY, JR., MD

*Systemic mycotic infections are increasing in frequency. Thus, it is necessary for physicians to be conversant with various antifungal agents, the chief form of treatment.*

During the past 15 years a number of advances in the fields of experimental and clinical mycology have led to a better understanding of the epidemiology, pathogenesis, and treatment of the systemic fungal diseases. Although many antibiotics and chemotherapeutic agents have been employed in treatment of these diseases, few have withstood adequate clinical trials. One of these is amphotericin B, the use of which will be discussed. Other promising agents available or under investigation will be reviewed briefly.

## AMPHOTERICIN B

Amphotericin B, a polyene antibiotic isolated in 1955 from *Streptomyces nodosus*, is effective against many of the fungi causing systemic mycoses. The mode of action of amphotericin B is related to the binding of the drug with the sterols in the protoplast mem-

brane of sensitive fungi. This alters the permeability of the cell walls and causes leakage of the potassium ions and glucose, resulting in destruction of the cell. The drug has no effect on bacteria<sup>1</sup>. This drug is the first and only commercially available antifungal agent with activity against most of the systemic mycoses. Amphotericin B inhibits the growth of *Blastomyces dermatitidis*, *Blastomyces brasiliensis*, *Coccidioides immitis*, *Cryptococcus neoformans*, *Histoplasma capsulatum*, *Torulopsis glabrata*, *Sporotrichum schenckii*, and all species of *Candida* in *in-vitro* concentrations of 0.02-1.0 ug/ml. Studies have shown that amphotericin B can prolong life and increase the number of survivors among animals with a variety of experimental mycotic infections. Eradication of infection using amphotericin B has been commonly achieved in subjects with histoplasmosis, coccidioidomycosis, blastomycosis and candidiasis; persistence of infection is usually the case in experimental cryptococcosis, aspergillosis and mucormycosis<sup>4</sup>.

For a variety of reasons, evaluation of the effect of any antifungal agent on the course of systemic mycoses in man is difficult. Nevertheless, available studies in man indicate that amphotericin B is of significant value in the treatment of the systemic mycoses. Amphotericin B is the agent of choice for treatment of several systemic mycotic infections, including histoplasmosis, North American blastomycosis, cryptococcosis, candidiasis and coccidioidomycosis. The drug is not as effective in aspergillosis, South American blas-

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tomycosis, mucormycosis, and disseminated sporotrichosis<sup>2</sup>. Clinical experience to date suggests that amphotericin B is indicated for all patients with cryptococcal meningitis, chronic forms of cavitary pulmonary histoplasmosis, the severe, acute pulmonary and progressive or disseminated types of coccidioidomycoses, disseminated aspergillosis, the severe forms of primary pulmonary, cutaneous and systemic or disseminated blastomycosis as well as *Candida* pneumonia, empyema, septicemia, endocarditis and meningitis. On the basis of isolated case reports, amphotericin B is also of value in selected cases of pulmonary cryptococcosis, acute primary histoplasmosis, mucormycosis, iodide-resistant sporotrichosis, and paracoccidioidomycosis<sup>4</sup>. Amphotericin B often causes toxicity, but because of its proved efficacy in the above-mentioned diseases, any patient with sufficient indication for this antibiotic should receive it. If proper precautions are exercised, it is unlikely that serious, permanent difficulty will be encountered<sup>2</sup>.

**METHOD OF ADMINISTRATION.** The drug is absorbed poorly from the gastrointestinal tract, and effective therapy against systemic or deep mycosis requires intravenous administration. It is insoluble in water but may be dispersed in a colloidal suspension for intravenous use. The intravenous preparation is available as a sterile lyophilized powder in vials of 50 mg of amphotericin B; 41 mg sodium desoxycholate with 10 mg dibasic sodium phosphate, 0.89 mg monobasic sodium phosphate, and 6.2 mg sodium chloride are added as buffers. The lyophilized powder is stable for a period of about 24 months. The reconstituted solution must be protected from light. It may be stored in the refrigerator for one week with little loss of potency. If there is any evidence of precipitation, the solution should be discarded<sup>1</sup>.

The drug is used intravenously in a concentration of 0.1 mg per ml of 5% dextrose solution. Treatment is usually started with a dose of 0.25 mg per kg and is increased very gradually, if tolerated, to a dose of approximately 1 mg per kg per day. The maximum dose should not exceed 1.5 mg per kg. Depending upon tolerance, the drug is given on consecutive or alternate days. The infusion should take at least six hours in order to avoid serious toxic reac-

tions. It is advisable to agitate the infusion bottle gently every 15 minutes in order to be certain that the drug is in proper colloidal suspension and that no precipitation has occurred. Rapid administration or the use of high concentrations of the drug may lead to convulsions, ventricular fibrillations and cardiac arrest<sup>3</sup>.

The duration of therapy depends upon the type, extent, and response of the mycosis but is seldom less than four or greater than eight weeks. Each patient receiving amphotericin B intravenously must be carefully monitored for side effects; these occur in almost every patient receiving the drug.

In fungal meningitis, amphotericin B may be administered intrathecally on alternate days or twice weekly, beginning with 0.1 mg dissolved in 2 to 3 cc of spinal fluid or distilled water and increasing the dose to a maximum of 0.5 to 0.7 mg if tolerated. Larger amounts may cause urinary retention, hyperpyrexia, arachnoiditis, and transverse myelitis, which may be reversible if the drug is discontinued. Transient paresthesias usually occur and are less extensive if the intraspinal administration is given while the patient is in the sitting position<sup>3</sup>.

The drug may also be given topically as in the eye (1 to 5 mg), intra-articularly (up to 25 mg), intrathoracically (up to 30 mg), into cutaneous lesions (up to 25 mg with 1% to 2% procaine every other day) or as an aerosol inhalant spray (5 mg every six hours)<sup>3</sup>.

**TOXICITY.** The reactions to intravenous administration of amphotericin B are frequent and potentially serious. Fortunately, they seem to be less serious in children and tend to decrease during a prolonged course of therapy. Anxiety, anorexia, chills, fever and malaise are common and may be partly controlled by the prior administration (30 minutes) of aspirin, antihistaminics, or chlorpromazine. Headaches, nausea, vomiting, abdominal pain and chest pains require a diminution in the total daily dose, particularly if these symptoms increase in severity or duration<sup>3</sup>. Impairment of renal function occurs in over 80% of patients treated. Renal damage occurs in direct relation to the total amount of drug given during a course of therapy<sup>1</sup>. Fortunately the effect on the kidneys seems to be temporary in most instances and disappears on discontinuation of the drug. Rarer toxic effects include albuminuria and other renal difficulties, anemia, thrombocytopenia, hypokalemia caus-



ing muscular weakness, duodenal ulcerations and hemorrhagic gastroenteritis<sup>3</sup>. Observation should be made to detect these complications at an early stage, when they usually are reversible. Other side effects include anaphylactic shock, convulsions, vertigo, thrombocytopenia, acute liver failure, chills and fever, thrombophlebitis, hypocalcemia, and abdominal pain. Headache, nausea, and vomiting are early toxic manifestations. Cardiac arrest or arrhythmias such as ventricular fibrillation may occur<sup>1</sup>. Thrombophlebitis occurs more commonly in children (owing to their small veins) and causes technical difficulties in prolonged courses of therapy. Simultaneous administration of 20 to 100 mg of soluble hydrocortisone in the intravenous infusion has been advocated to prevent toxicity, particularly from intrathecal injections<sup>3</sup>.

The following laboratory determinations should be made every three to four days or more frequently as indicated: hemoglobin, blood urea nitrogen, serum potassium, calcium, phosphorus, and creatinine. Electrocardiograms should be done weekly as routine, and more frequently if indicated<sup>1</sup>.

The blood urea nitrogen (BUN) should serve as a guide to dosage regulation in reference to toxicity. If the BUN exceeds 40 mg/100 ml, the drug should be discontinued for at least two days, or until the value returns to normal range. If medication has been discontinued for seven days or more, treatment should be reinitiated, beginning with a dose of 0.25 mg/kg/day. If determinations of serum levels of amphotericin B are available, these may be used as a guideline to dosage at least twice those necessary for inhibition of the fungus. In most instances a peak body fluid level of 1.5 µg/ml will give twice the minimum inhibiting concentration for most susceptible fungi<sup>5</sup>. This may result in the use of much smaller doses of the drug than indicated by mathematical estimates<sup>1</sup>.

Unfortunately, the criteria for amphotericin B dosage have been derived chiefly on the basis of toxicity and not necessarily therapeutic effectiveness. It appears that amphotericin B may have less risk of renal damage in children than in adults<sup>5</sup>.

#### HYDROXYSTILBAMIDINE ISETHIONATE

As early as 1945 certain of the aromatic diamidines were shown to have a suppressive effect on *Blastomyces dermatitidis* *in-vitro* and later in experimental blastomycosis in mice.

Early clinical studies suggested that stilbamidine and the less toxic derivative, 2-hydroxystilbamidine, produced favorable results in human infections caused by *Blastomyces dermatitidis*. When subsequent reports emphasized the high frequency of relapse and amphotericin B became available for clinical use, most clinicians abandoned use of 2-hydroxystilbamidine<sup>4</sup>.

Hydroxystilbamidine isethionate is occasionally chosen as the initial therapy of patients with blastomycosis because it is less toxic than amphotericin B. It is often effective, but a significant percentage of patients will fail to improve, or their disease will recur after apparent cure, and thus necessitate amphotericin B therapy. It may be useful in the treatment of blastomycosis in patients with pre-existing renal disease or in those in whom the disease is slowly progressive.

Although the optimum dosage in children has not been established, a total dose of between 6 and 7 g has been used. This may be administered in doses up to 225 mg daily (adult dose) for five days of each week. Based on this dosage the child's dose could be calculated as 135 mg/M<sup>2</sup>, or 4.5 mg/kg/day. Each milligram of drug should be diluted with 1 mg or more of 5% dextrose in water or isotonic sodium chloride solution. The fluid should be protected from light until intravenous administration is complete. The infusion time should be between 45 minutes and 2 hours; when the room temperature is high, the shorter time should be used. Rarely, the drug dissolved in 10 ml of diluent (preceding discussion) can be given by deep intramuscular injection, but this method is painful. Duration of treatment is judged by clinical improvement and the failure to demonstrate the etiologic agent<sup>2</sup>.

Adverse reactions include flushing, hypotension, tachycardia, dyspnea, syncope, chills and fever, urinary and fecal incontinence, edema, and formication and occasionally involvement of the fifth cranial nerve. These may be minimized by infusing dilute solutions slowly. Since the symptoms may result from histamine release, antihistaminics may be helpful<sup>2, 4</sup>.

#### SARAMYCETIN

X-5079C (saramycetin) is a water-soluble, polypeptide antifungal agent produced by a species of *Streptomyces* which was first isolated in 1961. This agent is active in experimental infections with *Histoplasma capsulatum*, *Blastomyces dermatitidis*, *Coc-*



## Therapy / RILEY

*cidiodes immitis* and *Sporotrichum schenckii* in mice. Saramycetin appears therapeutically active in blastomycosis, histoplasmosis and sporotrichosis. There is suggestive evidence of beneficial effects in Phycomycotic and *Madura* infections. The drug is not effective in coccidioidomycosis and candidiasis and is of questionable value in aspergillosis. The drug is given subcutaneously every six hours in a dose that varies from 3-17 mg/kg/day<sup>4</sup>. The drug is probably not fungicidal, and relapses are frequent in those initially responding to therapy (50 percent)<sup>3</sup>.

The drug is well tolerated. Significant side effects recognized to date are changes in tests of liver function and eosinophilia. Abnormalities are chiefly in the excretion of sulfobromophthalein and moderate rises in conjugated and unconjugated serum bilirubin. Microscopic studies of liver biopsies show the presence of periportal inflammation which also disappears after treatment is discontinued<sup>4</sup>.

### 5-FLUOROCYTOSINE

A new agent, 5-fluorocytosine, is a white crystalline solid with a molecular weight of approximately 129 and is fairly soluble in water. In experimental infections, 5-fluorocytosine has a protective effect when administered orally or intravenously to mice with experimental *Candida albicans* and *Cryptococcus neoformans* infections<sup>6</sup>. Clinical studies are still limited with this agent which is administered by the oral route. It has been found effective in patients with pulmonary cryptococcosis and in a few cases of cryptococcal meningitis. Good results have also been demonstrated in patients with serious *Candida* infections. Utz and associates<sup>7</sup> treated 15 patients with cryptococcosis using oral 5-fluorocytosine. These patients received 1-6 gm/day, in four equally-divided doses for a period of 14-42 days. Three patients with pulmonary disease alone improved, and 9 of 11 patients with meningitis also improved as judged by the inability to culture the microorganism from sputum or cerebrospinal fluid. However, four of nine patients with cryptococcal meningitis, who improved with 5-fluorocytosine therapy, relapsed during the follow-up period. A few patients with chronic cryptococcal meningitis unresponsive to am-

photericin B have responded favorably to 5-fluorocytosine<sup>9</sup>.

The observed adverse reactions to 5-fluorocytosine, based on the experience in 100 patients, have occurred chiefly in patients who have had other serious diseases with numerous complications in addition to their systemic mycotic infection<sup>10</sup>. Pancytopenia and leukopenia have occasionally been observed. A fall in hemoglobin and an elevation in the serum glutamic oxaloacetic and pyruvic transaminase have occurred in a small number of patients. Single instances of alopecia, malaise and diarrhea, dermatitis, thrombocytopenia and elevations in alkaline phosphatase, blood urea nitrogen, uric acid, sulfobromophthalein retention and serum bilirubin have also been reported<sup>4</sup>.

An optimal daily dose has not been established, but the recommended dose schedule is 150 mg/kg per day for a 6-12 week period of treatment<sup>10</sup>. The approximate half-life of 5-fluorocytosine in the body is four-to-eight hours. Consequently, each daily dose should be divided into four equal parts given at 6-hour intervals. The administration of 5-fluorocytosine to children has been limited. The dose recommended for children weighing less than 50 kg ranges between 1500 mg - 4500 mg per square meter of body surface per day<sup>4</sup>.

Experimental studies in rats indicate that 5-fluorocytosine is teratogenic. Consequently, use of 5-fluorocytosine is contraindicated in pregnant women.

### HAMYCIN

Hamycin, a newer antifungal polyene antibiotic produced by *Streptomyces pimprina*, closely resembles amphotericin B, has a virtually identical ultraviolet spectrum and an equivalent percentage content of carbon, nitrogen, and oxygen<sup>4, 6</sup>. It differs from amphotericin B in that it is soluble in methanolic

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calcium chloride, is supposedly better absorbed from the gastrointestinal tract and is more active in experimental infections in mice caused by *Histoplasma capsulatum*, *Cryptococcus neoformans*, *Blastomyces dermatitidis*, and *Coccidioides immitis*<sup>4</sup>. The alleged ability to produce effective antifungal concentrations of hamycin by oral administration suggested that this drug might have a potential role in the treatment of systemic mycotic infections in man. Clinical trials with this drug have provided variable results. In one study, apparent cures were observed in only two of seven patients with blastomycosis who received oral hamycin in total doses of 99-159 gm. Although a third patient showed clinical improvement, cultures remained positive for the infecting organism. The remaining four patients had more severe infections and did not respond to treatment<sup>8</sup>.

A micronized preparation of hamycin has recently been evaluated in five patients with blastomycosis and two patients with histoplasmosis, and apparent cures were obtained in four of the patients with blastomycosis and one with histoplasmosis. The remaining patients, although clinically improved, showed persistence of the causative organism. Concentrations of hamycin in serum were higher during treatment with the micronized preparation than with an equivalent dose of the tablet<sup>4</sup>.

Side-effects in man have been mainly nausea, vomiting, diarrhea, abdominal pain or a combination of these<sup>10</sup>. In contrast to am-

photericin B, impairment in renal function has not been observed. However, in animals the drug, by the parenteral route, is more toxic than amphotericin B. The dosage of the drug and the ultimate preparation have not yet been determined, but experimental studies are going on with an enteric coated preparation in amounts of 2-4 mg/kg per day given in four divided doses<sup>10</sup>. There is insufficient clinical experience with hamycin to assess accurately the potential of this drug in the treatment of systemic mycotic infections in man. □

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# The Development of American Medical Research and the Influence of John D. Rockefeller

## Part I

WILLIAM O. SMITH, JR.  
With the special help of  
ERMA McKEE

*The realization of America's potential for contribution to medical science was made possible by the evolution of certain unique cultural, socioeconomic, and scientific factors.*

Medicine can hardly hope to become a science until it can be endowed, and qualified men enabled to give themselves to uninterrupted study and investigation, on ample salary, entirely independent of practice.<sup>1</sup>

The idea for the founding of the Rockefeller Institute for Medical Research may be traced to John Frederick Gates, the author of these words. Gates was a Baptist minister, who, at the time of his initial contact with John D. Rockefeller in 1885, was president of the American Baptist Education Society. In this year, national Baptist leaders were soliciting support for the establishment of a great university and turned to Mr. Rockefeller. Because opinion was divided over whether to locate the

school in Chicago or in an eastern city, Rockefeller was skeptical. Then Gates, representing the Education Society, made a brilliant report in favor of founding the university at Chicago. In this document and other correspondence, Rockefeller recognized the analytical ability and intelligence of Gates. From this point he channeled his gifts to education through the American Baptist Education Society. A short time later Rockefeller asked Gates to join his staff. Gates opened an office in New York City in 1891 and began organizing the Rockefeller program. His tremendous energy and bold constructive imagination were tempered by a keen and practical business sense. These attributes equipped him perfectly for the huge task. As he gained experience, Gates began to supervise some of the Rockefeller investments. Soon he became as successful in business as he was in philanthropic administration.

Medicine had been one of Gates' interests for several years. His position as pastor had provided many contacts with physicians and patients. He had concluded that the doctor was guided by experience and tradition rather than by scientific knowledge. He was skeptical about the soundness of the treatment recommendations of both the "regular" (allopathic) and the homeopathic physicians. Gates affirmed that doctors told him that nine out of ten professional visits might just as well not have been made.<sup>2</sup>

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Gates, it must be acknowledged, had been exposed mainly to impoverished social areas and not to the leading men of the profession with the best available resources. This may account for his pessimistic outlook. It should also be recalled, however, that almost all scientific and clinical advances were being initiated in Europe, and only rarely in America.

Three years after joining Rockefeller's staff, Gates on several occasions discussed the effectiveness of the medical profession with a youthful student of his acquaintance. Gates asked him to recommend a textbook of medicine from which a layman might understand the teachings of the finest physicians. The student suggested William Osler's *Principles and Practice of Medicine*. Gates promptly obtained a medical dictionary and brought the *Principles* on his vacation in 1896. This clearly-expressed book totally absorbed his interest. Osler dealt with the whole field of internal medicine with a critical appraisal of the recent scientific information. This provided Gates with an excellent introduction to current medical knowledge, and reinforced his doubts about therapeutic measures. Apparently there were only a few diseases for which the cause, and even fewer for which a specific cure, was known. Following the reading of Osler's book, Gates commented on the neglected state of the scientific study of medicine:

When I laid down this book I had begun to realize how woefully neglected in all civilized countries and perhaps most of all in this country, had been the scientific study of medicine. I saw very clearly *why* this was true. In the first place the instruments for investigation, the microscope, the science of chemistry, had not until recently been developed. Pasteur's germ theory of disease was very recent. Moreover, while other departments of science, astronomy, chemistry, physics, etc., had been endowed very generously in colleges and universities throughout the whole civilized world, medicine, owing to the peculiar commercial organization of medical colleges, had rarely, if ever, been anywhere endowed, and research and instruction alike, had been left to shift for itself dependent altogether on such chance as the active practitioner might steal from his practice. <sup>2</sup> (pt. 23-24)

Gates' perception seems remarkably accurate, particularly with regard to the situation in the United States. The opportunity for the Rockefeller wealth to make an innovative and significant contribution to society lay open.

Upon returning from his vacation, Gates

wrote a memorandum outlining his concept of the utility of an institute for medical research. He emphasized the dearth of information about the causes of many of the infectious diseases plaguing humanity. He noted the important contributions from existing European institutes — the Koch Institute in Berlin, and the Pasteur Institute in Paris. He attached major importance to his argument that, even if the proposed institute should fail to make scientific advances, it would surely stand as a precedent for other donations and thereby lead to the development of medical research in America.<sup>1</sup>

The support of scientific research in the United States may be traced to the profits of private industry. Although in recent years profits of large corporations have been partly reinvested in industrial research, tax-supported governmental agencies have administered the funding of most scientific investigation. Until the 1930's, however, business prosperity had allowed the accumulation of immense wealth among individual citizens, and private endowments almost exclusively supported institutions and scientists engaged in many fields, including medicine.

Scientific activity at the beginning of this period was wholly dependent on an economic system which emphasized efficiency and practicality. This characteristic feature of the American capitalistic endeavor strongly influenced the evaluation of research. Business and political leaders with this attitude accepted endeavors which promised immediate applications. Scientific research based on new concepts could not be adapted to this utilitarian outlook.

There were two distinct currents of change which came into juxtaposition just prior to the turn of the century and set the stage for the rising tide of medical research in the United States. The first current was the development of scientific medicine. The second was the socioeconomic situation which influenced the degree and direction of research support.

In every country in which a durable advancement of medical science occurred, three successive stages may be recognized. In the first stage, the population depended on the trained physician for health care. Since no facilities existed for medical education, physicians were imported. In the second stage, the number of physicians was greater, some train-



ing was available and the profession was advancing, but physicians were not motivated to engage in or support independent scientific work. In the final stage, research work was taking place and was encouraged. Initially, foreign scientific training was essential. However, research in native institutions finally produced scientists of merit and thereby perpetuated itself.<sup>3</sup>

Scientific development may be viewed historically from an additional perspective. Efforts to cultivate scientific activity were begun by the academies, such as the Royal Society in England and the French Academy and, later, the American Philosophical Society and Academy of Arts and Sciences. Initially, learned and professional societies were voluntary organizations of individuals who saw the value of interchanging new concepts and findings. Subsequently, these organizations often received government assistance. Then there developed a mechanism of special endowment funds which provided grants and eventually research professorships which allowed freedom from teaching obligations. Finally, emerged the mature and refined institute for medical research with the sole purpose of advancing medical knowledge.<sup>4</sup> America in the mid-1800's resembled seventeenth century Europe in that biological research was sponsored by scientific academies rather than universities. Since then, American medical science has progressed through all the stages of development. <sup>3</sup> (p.272)

Two factors shaped the course of scientific medicine in this country. The restructuring of medical education was a prerequisite for its development. Also of major importance were the remarkable results of European science, notably the cell theory, cellular pathology, and the germ theory of disease. Whether educational reform or research success was of primary importance is debatable, but it is concluded that the development of medical research and progress in medical education were interdependent.

For many years there had been a continuing concern over the state of general education, which had traditionally been a popular philanthropic outlet. However, medical education had been so badly neglected that substantial reform was necessary in order to justify and attract financial support.

American students returning from abroad in the mid-1800's brought with them, in addition to the research inspiration, a recognition of the deplorable condition of medical education in this country in comparison with that in the progressive European institutions. Many prominent individuals were aware of these inadequacies. Native training, nevertheless, produced a few excellent physicians. Simon Flexner quoted William H. Welch as saying, "The results were often better than the system." From an appraisal of the typical medical school education during the mid-1800's, Flexner wrote:

The lecture was everything. Within the brief compass of four winter months the whole medical lore was unfolded in discourses following one another in bewildering sequence through a succession of long days; and lest the wisdom imparted should exceed the student's power of retention, the lectures were repeated precisely during a second year, at the end of which graduation with the degree of Doctor of Medicine was all but automatic. Of laboratory instruction there was none; the anatomical laboratory provided the one place where practical instruction was given, and yet the students managed somehow to become doctors, and ever so often good doctors at that . . . .

A profession based on so faulty a system of education could not survive in a country developing materially, becoming conscious of its intellectual deficiencies and sensitive to the larger world of which it now formed an integral part.<sup>5</sup>

Abraham Flexner stated that "efficient and progressive training is procurable only where original scientific activity is in progress." He noted that until the turn of the century medical educational institutions were mainly concerned with teaching, and regarded research as incidental or extraneous.<sup>4</sup> (p. 282) This provides one explanation for the poor quality of American medical education.

Before 1900 medical schools were not closely associated with universities. They lacked laboratories and adequate clinical facilities. Most medical schools still operated on a proprietary system, wherein practitioners exacted fees directly from enrolled students. Few medical students were college graduates; in fact, many could not have gained entrance to the established liberal arts colleges. The few pre-medical programs available at that time, moreover, were wholly inadequate. As George Corner pointed out in his history of the Rockefeller Institute, "What intellectual strength there was in the medical profession was over-



shadowed by a general mediocrity. Under such conditions medical science could not get a footing."<sup>2</sup> (p. 10)

The first steps toward restructuring medical education came in 1869 when a course in pre-medical studies was established at the Sheffield Scientific School at Yale through the efforts of Daniel Coit Gilman, who had graduated from this school. President Charles Eliot, installed at Harvard in 1869, was another leader in the revolution in medical education. He raised the entrance requirements of the medical school; he also elevated the quality of the instruction by prolonging and grading the courses, initiating laboratory exercises, and introducing demonstrations in clinical teaching. Such changes raised the standards of medical schools to the university level. The improvement aroused widespread interest and precipitated support from private donors, thus justifying Eliot's statement, "The first step toward endowment is to deserve it."<sup>5</sup>

Perhaps the most important event in terms of the development of medical research was the founding in 1876 of the Johns Hopkins University, with which a medical school was projected. Although the Johns Hopkins Hospital received its first patients in 1889, the opening of the medical school was delayed until 1893. With the establishment of the school and hospital, the United States gained a scientific research center of the first rank. William Osler reminisced that this event "came at a most favorable period, when the profession had at last awakened to its responsibilities, the leading universities had begun to take medical education seriously, and to the public at large had come a glimmering sense of the importance of the scientific investigation of disease and of the advantages of having well-trained doctors in a community."<sup>6</sup> President Gilman demonstrated keen insight into the potential of the new university. He and the governing boards accepted the plans of John Shaw Billings from the surgeon general's office for the construction of the hospital. Billings also suggested Welch and Osler as service chiefs and professors of pathology and medicine at the new medical school. Their appointments proved among the most fortuitous in American medical history.

For the first time, a medical school was organized within the framework of a university and modeled after the scientific pattern of progressive German institutions. The Johns Hopkins formed the principal center of scientific

effort in America. The brilliant men at this institution engendered a tremendous emphasis on medical research. The school adopted the philosophy that its responsibility for the instruction of medical students was no greater than its responsibility for the advancement of knowledge through original research.<sup>5</sup> (p. 508) From this moment, America ceased to be dependent on knowledge from other nations and took her place in medical science by contributions to solutions of fundamental medical problems.

The Hopkins innovation was perhaps more important for the example it set than for the product of its own efforts. Following the founding of this institution, there slowly took form a trend toward training physicians upon the basis of medical research. After 1890 other eastern schools and some progressive western institutions offered regular courses in preclinical scientific subjects under fulltime professors.

The discoveries made in France and Germany during the latter part of the nineteenth century constituted a second factor to the growth of scientific medicine in America. After its revolution, France achieved great strides in clinical teaching and diagnosis, which were facilitated by the development of pathological anatomy. French medicine led the world from 1800 to 1850. Later advances in the basic sciences created a situation unadaptable to medicine in France where clinical and research efforts were not joined. Despite these handicaps, the chemist Louis Pasteur contributed fundamental discoveries to bacteriology, which resulted in the control of infectious diseases. Later Claude Bernard also enhanced the French position by the introduction of a new methodology in physiological chemistry.

The scientific center at midcentury, however, shifted from France to Germany. Many German and American students had studied in Paris. German students filled with new con-

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cepts returned to a country where research carried prestige and an institutional framework stood already prepared. Americans, on the other hand, returned from France to find total apathy or, worse, an ideological opposition to scientific investigation. Thus, in Germany, modern experimental medicine developed in the last half of the century while American medicine lagged behind.

Aided initially by the government through state universities, and later through special institutes, medical research became more systematic in Germany than it had ever been in Paris. The institutes frequently brought together clinical observation and laboratory experimentation for the purpose of the application of discoveries to medical practice. Justus von Liebig and Johannes Purkinje were the principal innovators during the 1830's in development of the institutional organization of research. A few decades later there was a succession of brilliant individuals, including Johannes Muller, Carl Ludwig, Rudolf Virchow and Robert Koch. The investigations of the latter two great leaders and their associates in cellular pathology and bacteriology, provided such a tremendous impetus that Welch later remarked that the period from 1880 to 1890 was "perhaps the most wonderful decade in the history of medicine."<sup>7</sup>

Although the Germans pioneered the restructuring of research activity in the university and hospital environment, the French established the first institute concerned solely with research and without ties to any other institution. In 1886, the Pasteur Institute was organized as a private corporation financed by endowments, legacies, gifts, and the sale of biological products. Its purpose was the advancement of biological knowledge related to health and its scope was much broader than that of any existing institute.<sup>8</sup> It served as a model for similar institutions around the world, among the most important of which was the Rockefeller Institute for Medical Research.

American students flocked in increasing numbers to the European scientific centers. However, the French and German emphasis on pathologic and physiologic research did not appear to most American medical teachers to be closely related to clinical training. Even in the fourth quarter of the nineteenth century few dared enter the research field which offered lit-

tle reward either in terms of money or prestige, and which was actually frowned upon because of its impracticality. The medical profession, the schools, and the journals were interested solely in clinical matters. Prestige could only be acquired by a fashionable practice. While the Germans recognized the genius of Robert Koch and provided him with appropriate facilities, so complete was American apathy that the observations of William Beaumont on gastric digestion, and the differentiation between typhoid fever and typhus by William Gerhard, went largely unnoticed in their own country. A few individuals realized the importance of medical science and made significant contributions, but their paths were difficult without professional recognition.<sup>3, 9-12</sup> The American academic community provided no centers of learning to promote an appreciation of the theoretical and abstract. America lacked what has been termed "intellectual resonance" or a "tradition of learning." At the time when laboratory advances in Europe were revolutionizing the concepts of disease, there was not only a dearth of laboratory facilities but very few microscopes in this country, and even fewer physicians able to use them.<sup>3(p. 268), 13</sup>

It is not intended to imply that America totally lacked scientific activity. To the contrary, her amazing technological growth was based on progress in the physical sciences. But why is it that such a gap existed between medical science and physical science? Claude Bernard stated that the ultimate research goal is harder to reach in the biological than in the physico-chemical sciences because of the greater complexity of the biological phenomena.<sup>14</sup> Simon Flexner completed the explanation:

Under these circumstances it is no wonder that in a period when the physical sciences were being enriched by experiment, medicine still remained a subject of philosophical systemization—a condition called by the philosopher Locke 'the Romance-way of physic,' because it is more easy for men to build castles in the air of their own, than to survey well those that are on the ground.<sup>15</sup>

In addition, to the obstacles of professional attitude and American pragmatism, there were other barriers deeply entrenched in the social and cultural system. The most important of these was a strong opposition to dissection of the human body. This obstructive attitude extended not only to public disfavor of autopsies, but to the use of hospitals for clinical research



and teaching. An added burden was the insistence on separation of the government from medical as well as other public service activities. An offshoot of the laissez-faire philosophy, this attitude further prohibited research in hospitals.

Several signs of the progress in American medical science occurred near mid-century. There was a series of intricate technological achievements in surgery and anesthesia, which the American public could appreciate. Secondly, despite opposition on moral grounds, the first foothold for research in America came through the establishment of institutes of anatomy. Efforts of William Shippen and Caspar Wistar in the early decades of the nineteenth century, and later of William Horner and Joseph Leidy, established the Wistar Institute of Anatomy and Biology at the University of Pennsylvania. Such outstanding biological scientists only rarely blossomed in America within this period. Thirdly, the establishment of the Smithsonian Institution in 1846 aided in continuing research interest. By its work in general science the Smithsonian provided an intellectual example and fostered a new scientific climate which encompassed medicine.<sup>13(p.459)</sup>

A few years later an event occurred of specific importance to medical scholarship and research. From 1868 John Shaw Billings, on the staff of the US Surgeon General, assembled a comprehensive medical library under the auspices of the Army Medical Museum. The library and the brilliantly executed index catalog facilitated the organization of the medical literature. While visiting the librarian Edgar Erskine Hume in 1933, William H. Welch emphasized the significance of the Army Medical Library in his analysis of the great American contributions to medical science. He listed: (1) the discovery of anesthesia, (2) the discovery of insect transmission of disease, (3) the development of the modern public health laboratory, and (4) the Army Medical Library and its Index Catalog, which he considered the most important.<sup>13 (p.461)</sup> The Army Medical Museum and Library were a center for the little research conducted prior to the 1880's.

In 1876 Henry Bowditch, who had studied under Carl Ludwig in Leipzig, established at Harvard the first laboratory of experimental research in America. The German influence over American research continued through the

formation of the William Pepper Laboratory of Clinical Medicine at Philadelphia, and the establishment of the Johns Hopkins Medical School. The German tradition also affected other American health activities, including the United States Public Health Service.

The awakening of interest stemmed largely from those young men who returned from Germany in the 1870's determined to carry on their investigations and revitalize American medicine. William Welch offered the first course in microscopic pathology at Bellevue Hospital in New York. In 1878, Doctor Theophil Mitchell Prudden, also recently returned from Germany, opened a pathology laboratory in the basement of the College of Physicians and Surgeons in New York. These events initiated the movement toward modern medicine in America. Technology and basic science had advanced to some extent. Institutes and laboratory facilities were being established but, in general, medical research in its infancy was left to medical schools and independent workers for whom there was very little private support.

For a clearer understanding of the scientific setting at the turn of the century, the current health problems should be recalled. Typhoid fever, of which the cause and communicability were understood, could potentially be removed from health hazards through the enforcement of proper public health measures. On the other hand, specific treatment and prevention for many diseases, such as tuberculosis, had not been developed, and they could only be controlled from an environmental standpoint. From the high ground of the laboratory, sallies could be made to the health structure of society, and skirmishes fought with each antagonist encountered. Many diseases, such as poliomyelitis, would require vigorous scientific investigation before they could be successfully approached.

The control of infectious disease received the most attention in European laboratories and elsewhere. But in this country the importance of devoting men and facilities to such health problems only gradually came to be recognized by laymen and professionals. At this time, moreover, the United States gave an added challenge to the medical profession through its expanded world contacts, including the acquisition of the subtropical former Spanish colonies, in fulfillment of its "manifest destiny." The advances in education in a few medical



institutions in this country in the last quarter of the century, however, set the stage for the development of an institution devoted solely to medical research.

Social and economic conditions at the start of the twentieth century constituted the second current of change which facilitated the founding of a research institute. In concert with the advances in scientific medicine, these socioeconomic factors led to the fully developed and totally supported American research effort. In the words of Alan Gregg:

Medicine as we generally think of it is a part of health care, and health care is only part of man's endeavor to lead an abundant life. It is no surprise therefore to see different human societies treating medicine and medical research in different ways according to their cultures and historical traditions. The appreciation of medical research as a source of new knowledge, and of medicine as a means of applying it, depends then upon sociological and cultural factors which are elusive to explicit recognition because they are so all-pervading.<sup>16</sup>

During the gilded age of the nineteenth century national industrial expansion was rapid and uneven, with dislocations and privations in some sectors of the population. In the 1880's and 1890's governmental and private efforts to correct the social and cultural deficiencies through economic and philanthropic measures were largely ineffective. Concerned citizens believed the answer might come through a national appraisal of public morality and goals, which could best be defined through education and research. Into this atmosphere the first appeals for private financing were tossed.

The accumulation of wealth had occurred through several circumstances: (1) the economic system which promoted building of huge personal and corporate fortunes, (2) abundant natural resources, (3) an increasing pattern of urbanization, and (4) unparalleled advances in technology. The wave of industrial development in its full strength had broken on the American shore and left a new economic and social philosophy. The country was committed to a laissez-faire economic philosophy, and to a doctrine of social Darwinism. Religious sanctions promoted the acceptance of this concept. With this philosophy, the accumulation of wealth was regarded as the highest virtue.

At this time a new class of business giants emerged. Though many of these individuals came from established business and professional families, they loudly acclaimed the self-made man as their symbol. They believed in survival of the fittest and thus justified every step taken on the path to wealth. John D. Rockefeller expressed it this way: "The growth of a large business is merely the survival of the fittest. . . . The American Beauty rose can be produced in the splendor and fragrance which brings cheer to its beholder only by sacrificing the early buds which grow up around it."<sup>17</sup>

Social Darwinism and the laissez-faire attitude, however, do not provide a sufficient explanation in themselves for the failure of these industrialists to aid scientific research. These concepts opposed government aid to individuals or institutions conducting research, but they did not oppose private support. The failure of the industrialists to accept the evident responsibility is difficult to explain except by their devotion to personal gain. Although they controlled the political and economic power in this country, their lack of concern and their devotion to "Jeffersonian" ideals were so complete that they neither attempted to secure government support nor offered direct aid to research themselves. Instead, unmindful of the disturbing social implications of their activities, prior to 1895 these men concentrated on further amassing their fortunes and on gaudy social display.<sup>12 (p.42)</sup>

It should be realized that these economic barons were organizers of men and materials — masters of the administrative art.<sup>18</sup> They assessed everything through the cold logic of the business mind. Investments must produce sufficient returns. Their attitude represented American pragmatism and its emphasis on utility. The personal experience of the industrialists did not suggest that the "idle curiosity" of men devoted to basic research could result in tangible economic profits.

In view of the close connection between medical science and education in the modern era, it may seem that the wall of opposition to research support might have been breached through a willingness to aid medical education, but this was not possible. Until the 1890's, there was a general disdain of education among the self-made businessmen. Even Andrew Carnegie found comfort in statistics which indicated very few college graduates among the leading financiers and indus-



trialists. Others even contended that higher education was not only unnecessary for success, but that it was detrimental to a career in business. Several explanations have been offered for this attitude. Some believed that higher learning undermined rugged individualism. Classical curricula were portrayed as impractical and distant from actual life experience. Some felt that college training absorbed the most productive years of a young man's life, while others observed that graduates acted as if the diploma was an assured passport to success. These views indicate an intricately conceived bias against education.<sup>18</sup>

Religion played an important role among the forces responsible for the modification of the industrialists' attitude. Many American churchmen inculcated the Social Darwinistic viewpoint and thus gave approval to activities in line with this philosophy. But, in turn, these religious leaders demanded loyalty to the Church organization and lifelong adherence to the prevailing Protestant ethic. By espousing the axiom that the way to success lay through the Church, the clergymen strongly influenced the industrialists, who to a great extent were a religious group. The seeds of social consciousness were planted in the minds of most of the great philanthropists through admonitions such as that giving is more blessed than receiving, and that abundance is only justifiable in terms of the good that money could accomplish for others. This ideology was a primary stimulus to philanthropic endeavor and allowed other factors to expand the range of giving.

The increased sophistication of the economic system after 1890 led to the easing of educational prejudices. "The college of hard knocks was no longer equal to the task of training men for leadership in a corporate age."<sup>18</sup> (p.108) Giant corporations had drastically altered the opportunities for the self-made man. As competition for top positions increased, many firms raised employment standards by requiring college degrees. Once the new business leaders recognized the worth of education as a tool to economic success, they readily joined the aristocratic families in support of institutions of higher learning. Progressive educational leaders could now direct some financial resources to the field of scientific investigation.

One of the earliest philanthropists in America was George Peabody (1795-1869),

who established the Peabody Education Fund for the special benefit of southern colleges. Peabody provided a model of excellence and inspiration for the wealthy industrialists in future decades. In particular, he influenced the designers of the Carnegie and Rockefeller philanthropies.<sup>19</sup>

Philanthropy increased after the introduction of a tax system which imposed heavy burdens on the wealthy. The formation of foundations or generous donations to many charitable enterprises provided routes to escape from huge inheritance taxes. Andrew Carnegie, a proponent of inheritance taxation, said:

The growing disposition to tax more and more heavily large estates left at death is the cheering indication of the growth of a salutary change in public opinion. Of all forms of taxation this seems the wisest. Men who continue hoarding great sums should be made to feel that the country, in the form of the State, cannot thus be deprived of its proper share. . . .<sup>20</sup>

Carnegie strongly advocated the philosophy that the wealthy had an innate obligation. More articulate than many of his fellow millionaires, he authored many books on the stewardship of wealth. The basis of this doctrine was put forth in the *Gospel of Wealth*, published in 1900. He maintained that the rich man was obligated to consider his property a trust held for the less fortunate. Adherence to this ideal implied that the wealthy individual should give away the surplus beyond the needs of his own family. Carnegie insisted, however, that philanthropy must be constructive and promote the efforts of the recipient. Self-made men, such as Carnegie and earlier philanthropists like Peter Cooper and Ezra Cornell, based their ideal of stewardship on the assumption that the most responsible stewards would give as much thought to the dispensation of wealth as they had to its accumulation. Carnegie's admonition that "the man who dies thus rich dies disgraced," affected the attitudes of many leading individuals.<sup>20</sup> (p. 19)

The motivations for philanthropic activity varied among individuals. Some, like Peabody and Carnegie, thought giving away one's fortune a matter of honor, while others like Cooper, considered it a matter of conscience.<sup>18</sup> (pp.91-93) Personal experiences also influenced the direction of philanthropy. Peabody, for example, felt keenly his own lack of schooling and thus he gave to education. Because of his



nephew's specific interest, he aided science at Harvard and Yale.<sup>19</sup> (pp.53, 65)

The philanthropic interests of most benefactors surfaced late in life. Retirement allowed reflection on the ups and downs of a lifetime and provided adequate opportunity for the business of giving away rather than acquiring.

The changing fabric of society produced broader alterations in the attitude toward research. As in Europe, wealthy members of upperclass society furnished the initial funding for scientific investigation. By the mid-nineteenth century this class had diminished resources. The new industrialists were the only group who could fill the void. However, their emphasis on equalitarian opportunities and utilitarianism fostered the view that science was only a means to exploit natural resources in the interest of economic gain. Because the business class held the leadership role, the population as a whole accepted this perspective. The general public's appreciation of research was further weakened by the complexity of science.

The effect of assistance offered by businessmen to research efforts after 1900 brings into focus the magnitude of their role in American neglect of basic science prior to that time. Shryock stated that "the rather sudden emergence of basic science in the United States can be largely ascribed to the support of business leaders — support which was provided only after science had reached a point where its implications for technology became more apparent."<sup>21</sup> The powerful industrialist's acceptance that pure science as well as applied science was useful, precipitated a change in the public attitude. The American experience fits into the historical pattern wherein scientific activity has grown in response to economic need. However, certain segments of the social structure, threatened by the expansion of giant corporations, had other motivations. The middle class first sensed the inadequacy of health care, and in them arose both a moral indignation and humanitarian concern.

Additional social factors were at play, which created a favorable atmosphere for research. The year 1900 is designated as the beginning of the Progressive Era, implying a new social and political setting. America was now the

richest country in the world and a great power. The public acquired a sense of national importance and responsibility. This feeling produced a willingness to apply newfound strength in unexplored directions. The idea of man as a "creator," guiding rather than being driven by social, natural and supernatural forces, replaced the mechanistic, deterministic concept of the nineteenth century. Social Darwinism was altered to become "reform Darwinism." This interpretation emphasized Darwin's argument that the environment was the crucial factor in selection of the species, *ie* "survival of the fittest." Therefore, by changing man's environment, man himself would change. All these factors contributed to the national awareness of social problems. It should be emphasized that America's pragmatism was not discarded, but the posture toward medical research became compatible with it.

With the businessman and the public now susceptible to the plea for research support, it remained for the plea to be made. Professor John Tyndall expounded the need as early as 1872, when he lectured throughout the country. He urged that a more profound prosecution of research in pure science be carried out, and emphasized the need for endowments to maintain it. He justified basic research upon which medical knowledge depends by explaining that great discoveries of scientific truth "are not made by practical men . . . because their minds are beset by ideas which, though of the highest value in one point of view, are not those which stimulate the original discoverer." Tyndall pleaded:

Keep your sympathetic eye upon the originator of knowledge. Give him the freedom necessary for his researches, not overloading him either with the duties of tuition or of administration, not demanding from him so-called practical results—above all things, avoiding that question which ignorance so often addresses to the genius, "what is the use of your work?" Let him make truth his object, however impractical for the time being that truth may appear.<sup>22</sup>

Though difficult to accept in the 1870's, the arguments of Tyndall were used successfully by proponents in the 1890's. The eloquent Addison Brown demanded the prosecution of original research because the knowledge gained would rapidly advance the welfare of man in many lines. He asked for generous endowments from the wealthy for three specific purposes: (1) to insure systematic research by pro-



fessors as a part of the new university system, (2) to provide for a supply of investigators for the future through financial aid to post-graduate programs, and (3) to promote research interest and publication of results through gifts to scientific associations.<sup>9</sup> (pp.623, 637)

A direct appeal for support of medical research was made by George M. Gould in an address in 1893 before the American Academy of Medicine. In "The Duty of the Community to Medical Science," he stated:

The object of this writing is to encourage medical men by every means within their power to spread abroad throughout the community the knowledge of truth, awful in its significance and absolute in its application, a truth of which legislators and philanthropists are outrageously ignorant or scornful — the truth that there is no duty so imperative and no self-interest so evident as the duty and self-interest of the endowment of institutions of preventive and didactic medicine.<sup>23</sup>

Gould aimed his argument directly at the wealthy industrialists. He pointed out that in illness both rich and poor are dependent on the physician and that, ultimately, life and health transcend in importance power and wealth. Thus he underscored the usefulness of assisting the physician to improve his ability in the prevention and cure of disease. Gould astutely chose to demonstrate the financial good sense of support for medical research. He noted that the research scientist "saved the community more dollars in one year than all the endowments of all the theological schools of all time," and emphasized how little an investment was actually required to bring forth the benefits of medical science. Brown and Gould were representative of the growing numbers of respected individuals whose pleas for assistance

to medical science did not go unheeded by the wealthy.

There was still another aspect of the new attitude toward medical research. Society realized eventually that the expense of research was small in comparison to the toll taken by disease from humanity. Though an understanding of the theoretical research process was not immediately acquired, the purpose and potential of research was nonetheless admired. Thus, the greatest factor in its acceptance was the demonstration that cure of disease was now a possible consequence of basic research.

Despite all the forward motion, it should be recognized that in the last two decades of the nineteenth century medical science still met doubt and opposition, both within and without the profession. Suspicion of the bacteriological laboratories resembled the unfavorable attitude toward the dissecting room at midcentury. The anti-vivisectionist movement was just beginning. Homeopathy and Christian Science were among the viable competitors of the regular system of medical practice. Also, a mutual distrust arose between the full-time clinician and the laboratory investigator, a situation which continued for many years.<sup>12</sup> (p.70)

By 1895 activity in medical research had reached a "critical level." Changes in medical science and education had planted the seeds, while growing public awareness cultivated the field of an extensive research effort. The realization of the prevention and cure of infectious disease provided practical appeal. All that was needed was financial nourishment to produce scientific research in America. Potential support existed in the new industrialist class, and one of its members became an outstanding benefactor to medical research. (To be continued in the May issue of *The Journal of the Oklahoma State Medical Association*.)

## TELEPHONE MESSAGE

While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:

**232-8115**

A courtesy message center will be maintained by Southwestern Bell Telephone during Oklahoma Medical Summit in the Myriad Convention Center Exhibit area.



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# Rondomycin<sup>®</sup>

(methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q. i. d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



**HYPERTENSION — THE NATION'S CURRENT  
NUMBER ONE PUBLIC HEALTH PROBLEM?**

This May, high blood pressure becomes the subject of a major educational campaign aimed at both professionals and the general public. Actuarial studies published in 1959 by the life insurance companies showed a steady increase in mortality rates with each rise in increment of blood pressure. For example, of every 100 normotensive (BP <140/90 mm.Hg) white males, 78 would be expected to be alive 20 years later; of 100 males with blood pressures recorded as 140/90. 65 should be alive in 20 years later; of 100 males with blood pressures corded as 160/100, only 46 should be alive in 20 years. This nearly three-fold increase in mortality in the last group is due almost entirely to an excess of heart attacks, strokes and kidney failure.

In 1967 and 1970, two Veteran's Administration Cooperative Studies were reported showing a substantial reduction in the incidence of stroke, congestive heart failure and progressive renal failure in treated hyperten-



**News From  
The Oklahoma State  
Department of  
Health**

sives when compared to untreated controls, confirming earlier preliminary studies. The first study included patients with diastolic pressure >105 mm Hg; the second larger group, followed longer, included patients with diastolic pressures 90 to 105 mm Hg.

Data extrapolated from the National Health Examination Survey conducted in 1962 indicate there are 23 million Americans (20% of the adult population) with hypertension (>160 systolic, or 95 diastolic). The Chicago Heart Association Hypertension in Industry study (23,000 screenees) indicated that 60% of the hypertensives (>160 systolic, 95 diastolic) were unaware that they had high blood pressure; only one in eight was adequately treated. □

**COMMUNICABLE DISEASES IN OKLAHOMA FOR FEBRUARY, 1974**

DISEASE	February 1974	February 1973	January 1974	Total To Date	
				1974	1973
Amebiasis	—	3	2	2	4
Brucellosis	—	—	—	—	—
Chickenpox	91	202	44	135	216
Encephalitis, Infectious	3	—	3	6	1
Gonorrhea (Use Form ODH-228)	670	750	739	1409	1718
Hepatitis, A,B, Unspecified	128	82	80	208	117
Leptospirosis	—	—	—	—	—
Malaria	1	—	—	1	—
Meningococcal Infections	1	—	4	5	2
Meningitis, Aseptic	7	1	1	8	2
Mumps	51	50	23	74	58
Rabies in Animals	8	8	8	16	15
Rheumatic Fever	—	1	2	2	2
Rocky Mountain Spotted Fever	—	—	—	—	—
Rubella	3	21	10	13	23
Rubella, Congenital Syndrome	—	—	1	1	—
Rubeola	3	—	3	6	2
Salmonellosis	23	16	13	36	34
Shigellosis	13	3	12	25	16
Syphilis, Infectious (Use Form ODH-228)	11	113	13	24	178
Tetanus	—	—	—	—	—
Tuberculosis, New active	20	24	23	41	44
Tularemia	1	1	—	1	3
Typhoid Fever	—	—	—	—	1
Whooping Cough	3	5	1	4	7

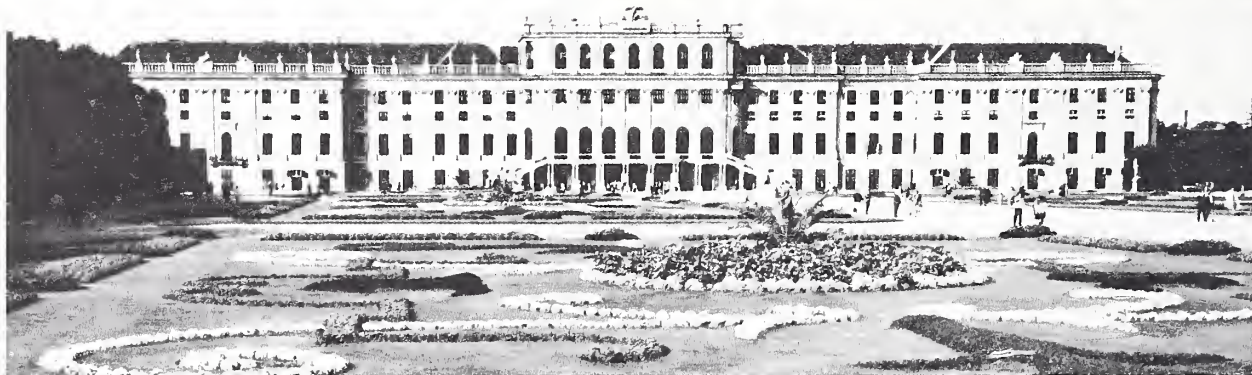
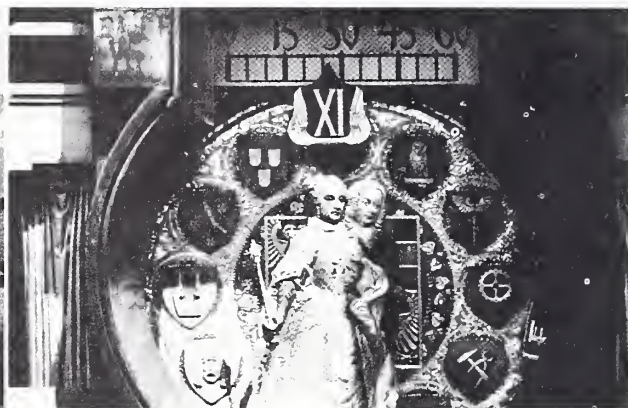
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# Oklahoma State Medical Association

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**OKLAHOMA CITY, AUGUST 29, 1974**

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Make Your Reservations Now — Space Strictly Limited



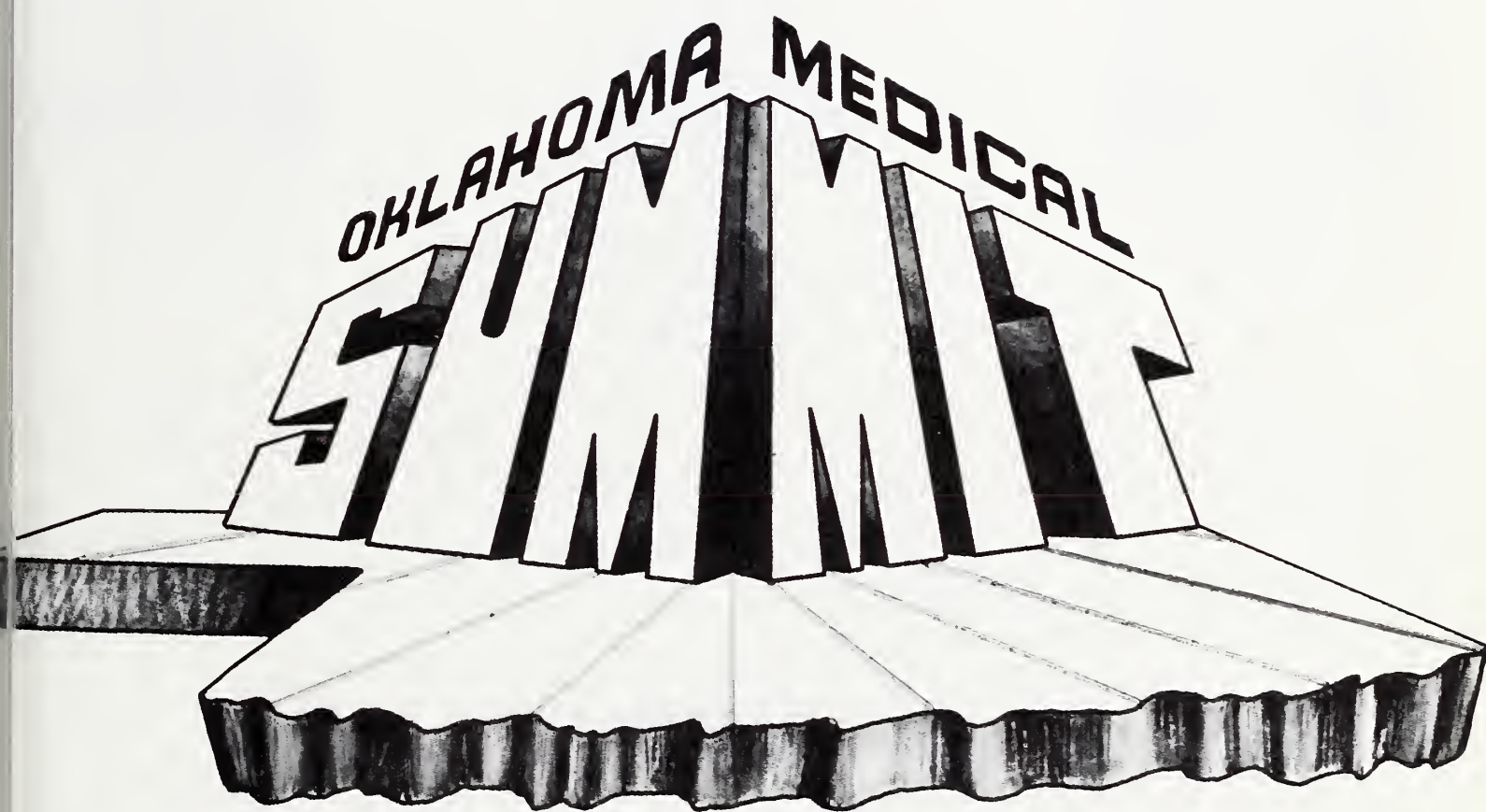
# JOURNAL

Volume 67—Number 4—April 1974

## OKLAHOMA STATE MEDICAL ASSOCIATION

# ANNUAL MEETING ISSUE

Featuring complete details about the largest  
medical convention in Oklahoma history



# May 12-15, 1974 at the Myriad Oklahoma City, Oklahoma

**Co-sponsors:** The Oklahoma State Medical Association, The Oklahoma City Clinical Society, The Oklahoma Academy of Family Physicians



# Oklahoma Medical Summit

OAFP—OCCS—OSMA

Oklahoma Medical Summit is the combined annual meetings of the Oklahoma Academy of Family Physicians, the Oklahoma City Clinical Society and the Oklahoma State Medical Association. It is scheduled for May 12th through 15th in Oklahoma City's Myriad Convention Center.

Oklahoma Medical Summit is anticipated to be the largest medical continuing education meeting ever held in the State of Oklahoma. Over fifty (50) hours of continuing education will be offered in addition to numerous courses of interest to Allied Health Professionals. Nearly twenty (20) such organizations will be conducting courses during the meeting.

Oklahoma Medical Summit will feature

numerous social functions including a cocktail reception in the beautiful new Mercy Hospital, a night at the Gaslight Dinner Theatre, the Keg and Oyster Party, and the social highlight of the year, the Inaugural Dinner in the Petroleum Club atop the Liberty Tower Building.

Oklahoma Medical Summit planning has taken literally thousands of man hours on the part of its various planning committees. Their purpose was to make this combination of the 68th Annual OSMA Meeting, 44th Annual Clinical Society Meeting, and 26th Annual Scientific Assembly of the Academy of Family Physicians one of the finest programs available. □

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# Oklahoma State Medical Association



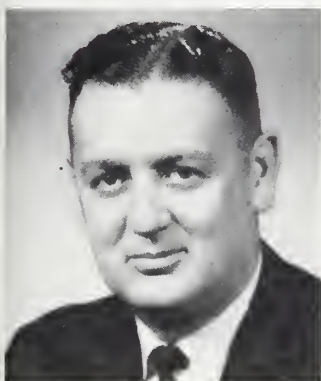
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Speaker-House of Delegates

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Alternate (1976) Ray V. McIntyre, MD, . . . . .Kingfisher

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Alternate (1976) Richard H. Burgtorf, MD, . . . . .Shattuck

### District V: Beckham, Blaine, Canadian, Custer, Roger Mills

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Alternate (1976) F. W. Hollingsworth, MD, . . . . .El Reno

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Trustee (1974) M. Joe Crosthwait, MD, . . .Midwest City  
Alternate (1974) James B. Eskridge, III, MD, Oklahoma  
City  
Alternate (1974) John W. DeVore, MD, . .Oklahoma City

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Alternate (1974) (Vacant)



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Trustee (1974) Paul A. Bischoff, MD, .....Tulsa  
Trustee (1974) William M. Benzing, MD, .....Tulsa  
Alternate (1974) Harold W. Calhoun, MD, .....Tulsa  
Alternate (1974) Myra A. Peters, MD, .....Tulsa

**District IX: Adair, Cherokee, McIntosh,  
Muskogee, Okmulgee, Sequoyah, Wagoner**

Trustee (1974) Francis R. First, Jr., MD, .....Checotah  
Alternate (1974) Burdge F. Green, MD, .....Stilwell

**District X: Haskell, Hughes, Latimer,  
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Mrs. Galen P. Robbins, Co-Chairman (OSMA)  
Mrs. Kenneth W. Whittington (OAFP)  
Mrs. Edmond H. Kalmon, Jr. (OCCS)

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Rex E. Kenyon, MD, Chairman  
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**Tennis Tournament**

Farris W. Coggins, MD, Chairman  
Lanny G. Anderson, MD  
Howard E. Hagglund, MD  
Lee A. Ison, MD



# Digest of Events

## HOTEL ACCOMMODATIONS

Headquarters for the Oklahoma Medical Summit will be the newly remodeled Skirvin Plaza Hotel in downtown Oklahoma City. A large number of newly redecorated rooms have been reserved for use by Oklahoma physicians. Physicians are requested to make their own reservations by writing directly to the Skirvin Plaza Hotel, 1 Park Avenue, Oklahoma City, Oklahoma 73101.

The following is a list of other hotels in the downtown area that are holding space for Medical Summit:

Holiday Inn Downtown, 520 W. Main, Oklahoma City.

Trade Winds Motor Inn-Central, 1800 E. Reno, Oklahoma City.

## REGISTRATION

General registration will be located in the Exhibition Area on the west side of the Myriad Convention Center. Hours will be from 8:00 a.m. until 5:00 p.m. each day during the meeting.

A special registration for members of the OSMA House of Delegates will be conducted Sunday afternoon, May 12th, prior to the opening session in the Skirvin Plaza Hotel's Imperial Ballroom. The presentation of delegates' credentials card will be necessary to receive special badges and portfolios containing the business items to be considered by the House of Delegates.

## OSMA BOARD OF TRUSTEES

The OSMA Board of Trustees will conduct its Annual Business Meeting Sunday morning, May 12th, starting at 10:00 a.m., in the Skirvin Plaza Hotel's Crystal Room.

## OAFP BOARD OF DIRECTORS

The Board of Directors of the Oklahoma Academy of Family Physicians will conduct a business meeting on Sunday afternoon, May

12th, starting at 1:00 p.m. in the Skirvin Plaza's Executive Suite.

## OSMA HOUSE OF DELEGATES

The OSMA House of Delegates will conduct two business sessions during Oklahoma Medical Summit. The opening session will be held Sunday afternoon, May 12th, in the Skirvin Plaza Hotel's Imperial Ballroom starting at 3:00 p.m.

Reference committees will meet starting at 7:30 a.m. the following morning, Monday, May 13th, in the Myriad Convention Center. Reference committee meetings are open to all members of the association.

The closing session of the House of Delegates is scheduled for 2:30 p.m., Wednesday afternoon, May 15th, in the Myriad.

All items of business introduced during the opening session on Sunday will be referred to one of the four reference committees for hearings on Monday morning. Open hearings are held on all the reports and resolutions to be considered by the House of Delegates.

Following the open reference committee hearings, the committees will prepare reports containing recommendations for presentation to the House of Delegates at its closing session on Wednesday afternoon. The election of officers will also be held during the closing session.

## SCIENTIFIC PROGRAM

Over fifty (50) hours of Continuing Medical Education will be offered during Oklahoma Medical Summit. Each of the three days will feature a number of different scientific sections available for physician attendance. Monday will include sections on Acupuncture, Radiology, Psychiatry, Cancer and Unexpected Death. Tuesday will have sessions on OB-GYN, Current Concepts and Treatment of Diabetes, Vertigo, Endocrinology, and Endometrial Cancer. The last day of Summit will have sections on Otolaryngology, Nephrology, Venereal Disease, Ophthalmology and Sickle Cell Anemia.



## WET CLINICS

There will be eight Wet Clinics offered during Oklahoma Medical Summit. These will be scattered throughout the three days and will be on Dermatology, Neurosurgery, Orthopedic Surgery and Otolaryngology.

## SOCIOECONOMIC SPEAKERS

Four nationally prominent speakers on Socioeconomic subjects will be featured during Oklahoma Medical Summit. The first will be a luncheon presentation by Russell Roth, MD, President of the American Medical Association, at noon on Monday. Tuesday's luncheon speaker will be Harry Schwartz, PhD, a member of the New York Times Editorial Board and author of the book *The Case For American Medicine*. Wednesday's luncheon speaker will be the President of the American Academy of Family Physicians, James Price, MD, Colorado.

The fourth Socioeconomic speaker will be Robert B. Hunter, MD, at 1:15 p.m. on Wednesday afternoon, May 15th. Doctor Hunter will keynote a session on "PSRO Update." He is a member of the American Medical Association's Board of Trustees, a member of AMA's Advisory Committee on Professional Standards Review Organization and a member of the eleven-doctor national advisory council on Professional Standards Review Organization to the secretary of HEW. He will be joined in his presentation by Hillard E. Denyer, MD, chairman of the Oklahoma Foundation for Peer Review.

## PHOTOGRAPHY SHOW

Oklahoma physicians and their spouses are invited to compete for prizes in the Oklahoma Medical Summit photo show. Entries may be either black and white or colored prints with a minimum size of 5 x 7 inches up to a maximum of 16 x 20 inches. (Sorry, no slides or transparencies.) Photos may be of any subject matter and no special mountings or frames are required. First, second, and third place awards will be made for the best three black and white and three color photos. A grand prize for "best of show" will also be given.

All entries will be displayed in the Exhibit Area and will be judged the opening day of Oklahoma Medical Summit. (Persons interested

should contact Ed Kelsay, Associate Executive Director of the OSMA).

## SPEED READING

A speed reading course for physicians and their spouses is being presented during Oklahoma Medical Summit. Dimensional Reading, Inc. will conduct the four-day course. The first session will be held Sunday morning from 9:00 a.m. until 12:00 noon. The remaining sessions are from 4:00 p.m. until 6:00 p.m. on Monday, Tuesday and Wednesday.

Persons interested in the speed reading course should contact Ms. Joyce Turley, Dimensional Reading, Inc., 3535 NW 58th, Oklahoma City, Oklahoma 73112. Tuition for the course is \$50.00.

## ALLIED GROUPS

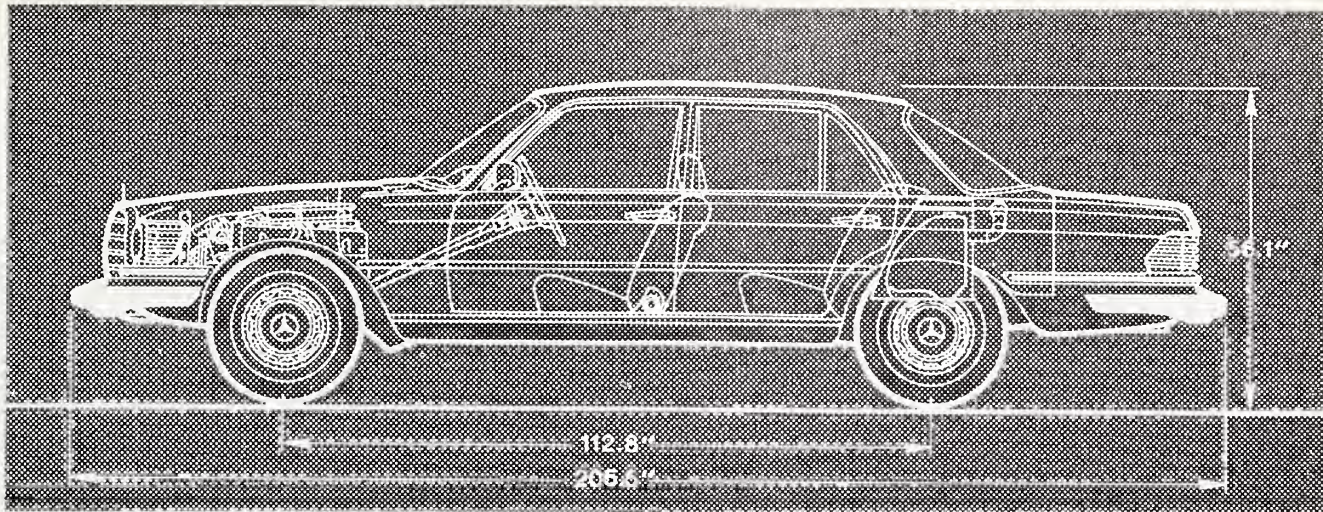
Nearly twenty (20) allied para-medical groups will conduct meetings in conjunction with Oklahoma Medical Summit. The programs for each of these meetings will be printed in the official program to be distributed at the registration during Medical Summit. All meetings held during Medical Summit are open to all registrants.

The following is a partial listing of the allied groups that will be meeting: Association of Nurse Anesthetists, Medical Technologists, Medical Records Association, Operating Room Nurses, Physical Therapists, Dieticians, Operating Room Technicians, Registered Nurses Association, Cytopathology Society, LPN Association, Clinic Managers' Association, Occupational Therapists, Physician's Associates, and the OB-GYN Nurses Association.

## EXHIBITS

Primary financial support for the Oklahoma Medical Summit is being provided by the technical exhibitors (see roster on page 170). The exhibit area, which will also feature scientific, institutional displays, and the photo show, will be in the Exhibition Hall of the Myriad Convention Center. Viewing hours will be from 8:00 a.m. until 5:00 p.m. Monday through Wednesday. □





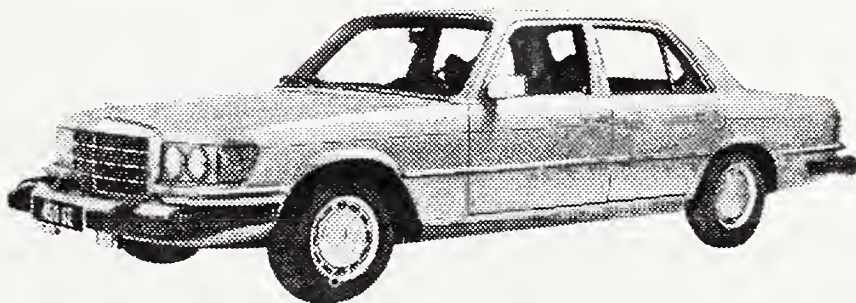
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# Technical Exhibitors

The Technical Exhibits of Oklahoma Medical Summit may be seen in the Exhibition Area of the Myriad Convention Center.

- |   |   |
|---|---|
| <b>AAFP Disability Plans, Inc.</b>                    | <b>*Merck, Sharpe &amp; Dohme</b>             |
| <b>Abbott Pharmaceutical Products, Inc.</b>           | <b>Merrell-National Laboratories</b>          |
| <b>Allergy Laboratories, Inc.</b>                     | <b>Metro Med., Inc.</b>                       |
| <b>Astra Pharmaceutical Products, Inc.</b>            | <b>Meyer Laboratories, Inc.</b>               |
| <b>Ayerst Laboratories</b>                            | <b>Mission Pharmacal Company</b>              |
| <b>Bella Vista Village</b>                            | <b>Mutual Federal Savings &amp; Loan</b>      |
| <b>Beverly Hills Hospital, Inc.</b>                   | <b>National Medical Credit Association</b>    |
| <b>Blue Cross &amp; Blue Shield Plans of Oklahoma</b> | <b>Oklahoma Micro-Systems</b>                 |
| <b>Boehringer-Ingelheim, Ltd.</b>                     | <b>Oklahoma Regional Medical Program</b>      |
| <b>Ralph L. Bolen Imports, Ltd.</b>                   | <b>Organon Pharmaceutical</b>                 |
| <b>Bomiseco Labs, Inc.</b>                            | <b>Ortho Pharmaceutical Corporation</b>       |
| <b>Bristol Laboratories</b>                           | <b>Parke Davis &amp; Company</b>              |
| <b>Bryan Institute</b>                                | <b>Phona-Grams Systems</b>                    |
| <b>Burroughs Wellcome Co.</b>                         | <b>Physicians' Planning Service Corp.</b>     |
| <b>Burton, Parsons &amp; Company, Inc.</b>            | <b>*The Purdue Frederick Company</b>          |
| <b>Carnrick Laboratories</b>                          | <b>Riker Laboratories, Inc.</b>               |
| <b>Ciba Pharmaceutical Company</b>                    | <b>A. H. Robins Company</b>                   |
| <b>Coca-Cola USA</b>                                  | <b>Roche Laboratories</b>                     |
| <b>Cooper Laboratories, Inc.</b>                      | <b>J. B. Roerig Division</b>                  |
| <b>Jackie Cooper Leasing, Inc.</b>                    | <b>Wm. H. Rorer, Inc.</b>                     |
| <b>Credit Service, Inc.</b>                           | <b>Ross Laboratories</b>                      |
| <b>Depuy-Rogers Associates</b>                        | <b>Safeguard Business Systems</b>             |
| <b>Dorsey Laboratories</b>                            | <b>Sandoz Pharmaceuticals</b>                 |
| <b>The Dow Chemical Company</b>                       | <b>Schering Corporation</b>                   |
| <b>Eaton Laboratories</b>                             | <b>Scott-Rice Furniture Co.</b>               |
| <b>The Emko Company</b>                               | <b>Searle Laboratories</b>                    |
| <b>Encyclopaedia Britannica</b>                       | <b>Seven-Up Bottling Co.</b>                  |
| <b>Flint Laboratories</b>                             | <b>Smith, Kline &amp; French Laboratories</b> |
| <b>Fuller Laboratories, Inc.</b>                      | <b>Southwestern Bell Telephone Co.</b>        |
| <b>Geigy Pharmaceuticals</b>                          | <b>E. R. Squibb &amp; Sons, Inc.</b>          |
| <b>Grolier Interstate</b>                             | <b>Stover Corporation</b>                     |
| <b>Hoechst Pharmaceuticals, Inc.</b>                  | <b>Stuart Pharmaceuticals</b>                 |
| <b>Ives Laboratories, Inc.</b>                        | <b>Syntex Laboratories, Inc.</b>              |
| <b>Lakeside Laboratories, Inc.</b>                    | <b>Tri-State Pharmaceutical</b>               |
| <b>Lederle Laboratories</b>                           | <b>The Upjohn Company</b>                     |
| <b>Eli Lilly and Company</b>                          | <b>USV Pharmaceutical Corporation</b>         |
| <b>Loma Linda Foods</b>                               | <b>Veazey Best Rents</b>                      |
| <b>Mallinckrodt Pharmaceuticals Products Division</b> | <b>*Web Con Pharmaceuticals</b>               |
| <b>Marion Laboratories, Inc.</b>                      | <b>Winthrop Laboratories</b>                  |
| <b>Meade-Johnson Laboratories</b>                     | <b>Wyeth Laboratories</b>                     |
| <b>Medical Plastics Laboratory, Inc.</b>              |   |
| <b>Medtronics, Inc.</b>                               |   |

**\*Contributors to scientific program.**



# Scientific And Institutional Exhibitors

"Xeroradiography" — Ralph E. Taupmann, MD

"Cancer Information Center" — Southern Medical Association

"Ready To Help You!" — The Visiting Nurse Association

"Physician's Assistant Program" — University of Oklahoma Physicians Associate Program

"Cromolyn Sodium in Pollen Induced Asthma" — Alvin D. Wert, MD

"Lipid Research Clinic Program" — Thomas F. Whayne, Jr., MD, PhD

"Poison Information Center" — Oklahoma State Department of Health

"Cardiovascular Computer System" and Cardiovascular Clinic Hypertension Protocol" — Galen P. Robbins, MD

## PHYSICIANS PHOTO CONTEST

Physicians and spouses interested in photography are invited to enter the Oklahoma Medical Summit Photo Contest to be held during the May 12th-16th meeting at the Myriad Convention Center.

The rules are as follows:

Rule 1: All entrants must be members of at least one of the sponsoring organizations of Oklahoma Medical Summit (OAFP, OCCS, or OSMA) or the spouse of a member.

Rule 2: Entries may be either black and white or color *prints* with a minimum size of 5 x 7 inches up to a maximum of 16 x 20 inches. (Sorry, no slides or transparencies.)

Rule 3: Photos may be of any subject matter (portrait, scenic, general interest, scientific, etc.)

Rule 4: All entries must be in the Oklahoma State Medical Association office no later than Thursday, May 9th . . . or entries may be

brought to the Myriad Convention Center on Sunday afternoon, May 12th.

Rule 5: Each entry must be clearly marked so that its ownership may be easily ascertained. All photos will be returned to their owners after the Oklahoma Summit Meeting.

Rule 6: No special mountings or frames are required. However, it would be appreciated if the photos were at least matted on some form of stiff backing.

Rule 7: First, second, and third place awards of \$75.00, \$50.00 and \$25.00 will be made for the best three black and white and three color photos. A \$100.00 prize will be awarded to "best of show."

MAIL OR SHIP ENTRIES TO: Oklahoma State Medical Association, Attention, Mr. Ed Kelsay, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118. ☐

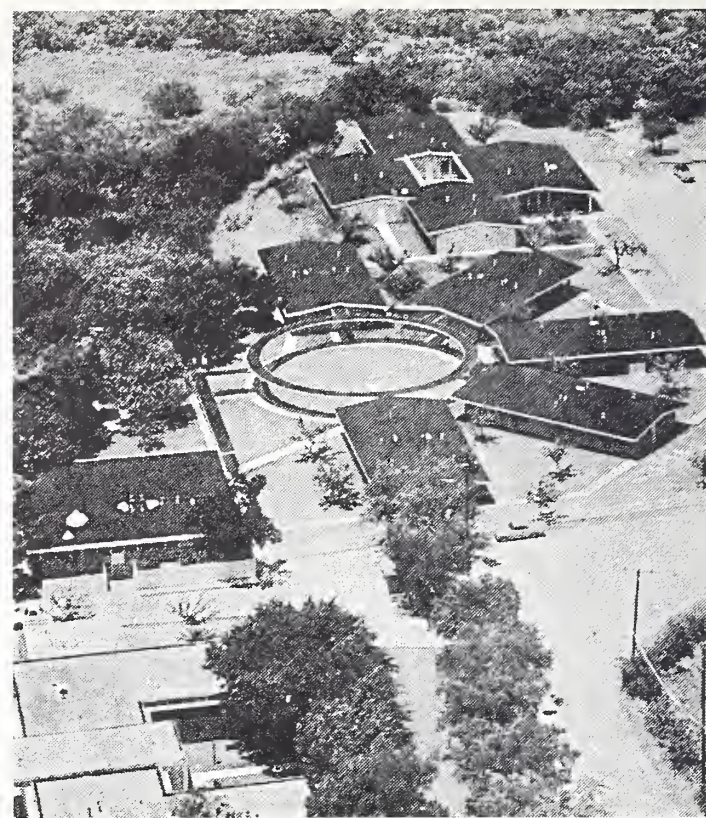
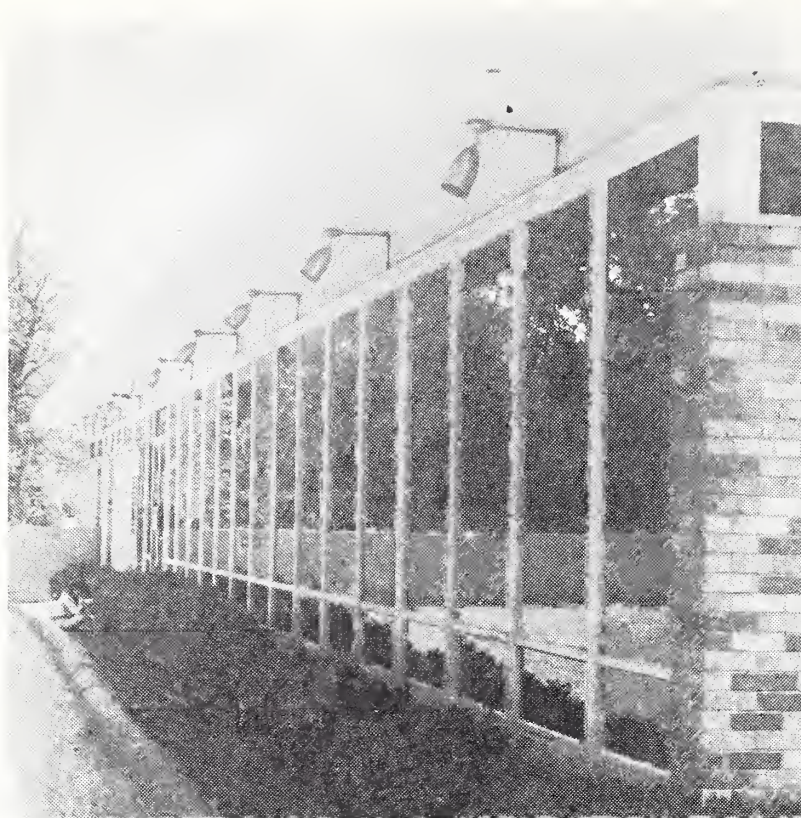
## TELEPHONE MESSAGE

While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:

**232-8115**

A courtesy message center will be maintained by Southwestern Bell Telephone during Oklahoma Medical Summit in the Myriad Convention Center Exhibit area.





# **BEVERLY HILLS HOSPITAL BEVERLY HILLS CLINIC**

## **PSYCHIATRY INPATIENT - OUTPATIENT DEPARTMENT OF ADOLESCENT PSYCHIATRY**

A Private 115 bed psychiatric hospital located in Oak Cliff on 18 acres amidst natural wooded surroundings. A multi-approach treatment center of neurologic and all psychiatric disorders. Treatment modalities include Somatic Therapy, Milieu Therapy, Chemotherapy, Individual and Group Therapy, Transactional Analysis, Gestalt, and Behavior Modification. Complete facilities for OT-RT under the division of trained personnel. An individually directed program based on full diagnostic evaluation and actual performance administered by a staff skilled in special education and problems of the adolescent and young adult.

### **PSYCHIATRY**

Jackson H. Speegle, M.D.  
Glenn A. Bacon, M.D.

Fred H. Jordan, M.D.  
Joseph H. Lindsay, M.D.

### **PSYCHOLOGY**

George R. Mount, PhD  
Donald L. Whaley, PhD

Tom I. Payton, MS  
Patrick R. Barnes, MS

### **DIRECTOR OF NURSES**

Rosella Sharp, R.N.

### **O.T. AND R.T. DIRECTOR**

Wanda Wiggins, B.S.

### **EDUCATION DIRECTOR**

William E. Nix, A.M.

### **COURTESY STAFF**

**1353 North Westmoreland Avenue, DALLAS, TEXAS 75211**

**214 331-8331**



# PROGRAM

All Events Will Be in the Myriad Convention Center Unless Otherwise Noted.

## Sunday Morning, May 12th

- 10:00 a.m. OSMA BOARD OF TRUSTEES.** The annual business meeting of the medical association's Board of Trustees will be held in the Crystal Room of the Skirvin Plaza Hotel.
- 12:00 noon DIRECTORS AND TRUSTEES LUNCHEON.** The Board of Trustees of the OSMA and the Board of Directors of the Oklahoma Academy of Family Physicians will have a joint luncheon in the Skirvin Plaza Hotel's Balinese Room.

## Sunday Afternoon, May 12th

- 1:00 p.m. OAFP BOARD OF DIRECTORS.** The annual meeting of the Oklahoma Academy of Family Physicians Board of Directors will be held in the Executive Suite of the Skirvin Plaza Hotel.
- 3:00 p.m. OSMA HOUSE OF DELEGATES.** The opening session of the association's House of Delegates will be held in the Skirvin Plaza's Imperial Ballroom.
- 5:00 p.m. EARLY BIRD PARTY.** The first social event during Oklahoma Medical Summit will be the Early Bird party. It will start with a bus ride from the Skirvin Plaza Hotel to the new Mercy Hospital at 5:00 p.m. A cocktail reception will be held in the hospital from 5:30 until 6:45 with an opportunity for all persons to visit the new facility. This will be followed by dinner and a play at Oklahoma City's Gaslight Dinner Theatre. The play will be "Fiddler On The Roof." Tickets will be \$9.00 per person. (Buses are a convenience for those persons staying in downtown hotels).

## Monday Morning, May 13th

- 7:30 a.m. OSMA REFERENCE COMMITTEES.** The four reference committees of the OSMA House of Delegates will meet in assigned rooms in the Myriad Convention Center to discuss association business.
- 8:00 a.m. GENERAL REGISTRATION.** General registration for Oklahoma Medical Summit will be on the first floor of the Myriad Convention Center.
- 8:10 a.m. ACUPUNCTURE FILM.** A film describing "Acupuncture Anesthesia for Surgical Operations" will be shown.
- 9:00 a.m. ACUPUNCTURE.** Topics to be discussed during this session will include "Modern Acupuncture and Western Medicine" and "Acupuncture in Prospective with Emphasis on Rheumatic Diseases and Complications of Acupuncture." Speakers will include Yiu Wing Choi, MD, a research scientist at the University of



Southern California Medical Center and the University of Southern California School of Dentistry; and Richard J. Kroening, MD, in the private practice of internal medicine in Studio City, California. The doctor is a consultant in rheumatologic difficulties.

- 11:00 a.m. **RADIOLOGY.** Jerome F. Wiot, MD, will present "Is This Chest Film Normal?"

## Monday Afternoon, May 13th

- 12:15 p.m. **LUNCHEON.** Guest speaker for the luncheon will be Russell Roth, MD, President of the American Medical Association.
- 1:45 p.m. **PSYCHIATRY.** Topics will include "Practical Psychotherapy Techniques" "How to Mend Your Old Cocks," and "Problems of the Adolescent." Beverly T. Mead, MD, will be the principal speaker. The doctor is professor and chairman of the Department of Psychiatry, Creighton University School of Medicine, Omaha, Nebraska. Local participants will include Harold J. Binder, MD, and Ed Norfleet, MD.
- 1:45 p.m. **COLON AND RECTAL CANCER.** A special seminar is being presented by the Oklahoma Division of The American Cancer Society and will feature such topics as "Principles of Colostomy Surgery," "Fibrotic Colonscopy," "Management of Colon Polyps," "Screening for Colon Cancer," and "Treatment of Advanced Colon and Rectal Cancer." Speakers will include James Hartsuck, MD, Director of Surgery, University of Oklahoma Health Sciences Center; Max Gregory, MD, Clinical Instructor, Department of Medicine, OU Health Sciences Center; Robert Freeark, MD, Director of Division of Surgery, Cook County Hospital, Chicago; Rupert B. Turnbull, MD, Head, Department of Colon and Rectal Surgery, Cleveland Clinic.
- 1:45 p.m. **SUDDEN UNEXPECTED DEATH.** This seminar is being presented by the Oklahoma Heart Association. Topics will include "Sudden and Unexpected Death—The Identification of Patients at Risk," "Sleep, Stress and Sudden Death," and "Clinical Consideration and Prevention of Sudden Death." Speakers will include Louis Kuller, MD, Professor and Chairman, Department of Epidemiology and Microbiology, University of Pittsburgh Graduate School of Public Health; C. G. Gunn, MD, Professor of Medicine, OU Health Sciences Center; and Leonard A. Cobb, MD, Professor of Medicine, University of Washington, School of Medicine, Seattle and Director, Seattle Mobile Intensive Coronary Care Project.
- 5:00 p.m. **KEG AND OYSTER PARTY.** This party for registrants at Oklahoma Medical Summit is being sponsored by Marion Laboratories. Delicacies from the briney deep and the cool brew will prepare doctors for an evening on the town.



## Tuesday Morning, May 14th

- 7:00 a.m. OAFP ANNUAL MEMBERSHIP BREAKFAST.** The annual membership breakfast and meeting of the Oklahoma Academy of Family Physicians will be held in the Skirvin Plaza Hotel's Imperial Ballroom. All members of the academy are cordially invited to attend this important function.
- 8:00 a.m. GENERAL REGISTRATION.** Oklahoma Medical Summit Registration will be conducted on the first floor of the Myriad Convention Center.
- 8:15 a.m. CARDIAC RESUSCITATION.** Robert M. Smith, MD, will present a demonstration on cardiac resuscitation, "Are You Prepared to Start This Heart?"
- 8:15 a.m. USE OF THE LAPROSCOPE.** This special film will be shown before the opening of the OB-GYN section.
- 9:00 a.m. OBSTETRICS AND GYNECOLOGY.** Topics to be presented include "Sexual Problems," "Anemia in Obstetric and Gynecologic Practice," "Abnormal Pap Smears 'What to Do When,'" and "Management of Toxemia of Pregnancy." Guest speakers will include Preston W. DeShan, MD, Clinical Professor and Chairman of the Department of Obstetrics and Gynecology, Texas Tech University School of Medicine; Robert Messer, MD, Chairman, Department of Obstetrics and Gynecology, University of Nebraska Medical Center; and Norman Gant, MD, Department of Obstetrics and Gynecology, University of Texas, Southwestern Medical School at Dallas.
- 9:00 a.m. CURRENT CONCEPTS AND TREATMENT OF DIABETES.** This is another program of general interest to all physicians and will include topics on "Diagnosis of Early Adult-Onset Diabetes," "Current Concepts of Treatment for Diabetic Retinopathy," and "Newer Concepts of Treatment of Diabetes." Two of the topics will be presented by Edgar A. Haunz, MD, Professor of Medicine, University of North Dakota School of Medicine. He will be joined by Charles P. Wilkenson, MD, an Oklahoma City Ophthalmologist.
- 9:00 a.m. VERTIGO.** This section on the care and treatment of the dizzy patient will include topics such as "Dizziness From Tibular Origin," "Dizziness From Ocular Imbalance," and "Dizziness From Systemic Problems." The entire faculty for this section is from Oklahoma and includes W. B. Moran, MD an Oklahoma City Laryngologist; Thomas E. Acers, MD, Chairman of the Department of Ophthalmology, OU Health Sciences Center; and Richard Dotter, MD, an Oklahoma City Neurologist.

## Tuesday Afternoon, May 14th

- 12:15 p.m. LUNCHEON.** Guest speaker for the Tuesday luncheon will be Harry Swartz, PhD, Editorial Board of the New York Times, Visiting Professor of Medical Economics, Columbia University and author of "The Case For American Medicine."
- 1:45 p.m. ENDOCRINOLOGY.** Topics will include "Basic Screening Procedures For Endocrinologic Diseases in the Outpatient" and "Newer Concepts in the Regulation of Menstrual Cycle." A panel will discuss "Practical Endocrinology." Steven Landgarten, MD, and Antonio Scommegna, MD, will join Doctor Norman Gant, MD, in presenting the program.



- 1:45 p.m. ENDOMETRIAL CANCER.** The Oklahoma County Unit of The American Cancer Society is presenting this special program. Topics will include "Review of Histological Changes in Borderline Endometrial Lesions," "Endometrial Disease in Young People," "Diagnosis of Endometrial Cancer," "Management of Endometrial Cancer," and "Treatment of Advancement of Endometrial Cancer." James A. Merrill, MD, Chairman of the Department of Gynecology and Obstetrics at the OU Medical Center and Gordon K. Jimerson, MD, Associate Professor in the department will join with Robert H. Messer, MD, Chairman of the Department of Obstetrics and Gynecology at the University of Nebraska Medical Center, and Preston W. DeShan, MD, Chairman of the Department of Obstetrics and Gynecology at Texas Tech University School of Medicine, Lubbock, to present the program.
- 6:30 p.m. COCKTAIL RECEPTION.** The cocktail reception before the Inaugural Dinner will be held in the beautiful new Petroleum Club on top of the Liberty Tower Building in downtown Oklahoma City.
- 7:30 p.m. INAUGURAL DINNER.** This dinner will honor the Presidents-Elect of the Oklahoma Academy of Family Practice, The Oklahoma Clinical Society, and the OSMA. The banquet will be built around a 12 oz. KC sirloin with appropriate wine. Entertainment will be provided by Mr. Mark Russell, Washington, D.C., one of the country's best known political satirists. Tickets for the cocktail reception, banquet, and entertainment are \$14.00 per person.

## Wednesday Morning, May 15th

- 8:00 a.m. GENERAL REGISTRATION.** General registration for Oklahoma Medical Summit will be on the first floor of the Myriad Convention Center.
- 9:00 a.m. OTOLARYNGOLOGY.** Gerald M. English, MD, will present a special session on otolaryngology covering such topics as "Fracture of Frontal Bone," "Cervical Esophagostomy in Head and Neck Tumors," and "Genetics in Otolaryngology."
- 9:00 a.m. NEPHROLOGY.** This scientific session will start with a film entitled "Renal Dialysis." Earl Ginn, MD, Professor of Medicine at the Vanderbilt School of Medicine, Nashville, Tennessee, will present "Management of the Patient With Chronic Progressive Renal Failure." He will then be joined by three Oklahoma physicians for panel discussion on Nephrology; L. O. Laughlin, MD, David Browning, Jr., MD, and Sol Papper, MD.
- 9:00 a.m. VENEREAL DISEASE.** The Oklahoma State Health Department is sponsoring this section. Topics will include an overview of venereal disease from the national and state standpoints and "Current Concepts In the Management of Gonorrhea and Syphilis." Participants will include Ralph H. Henderson, MD, Chief of the Venereal Disease Branch, Bureau of State Services, Center for Disease Control, US Public Health Service, and his Assistant Chief, Michael F. Rein, MD. The Oklahoma scene will be presented by Robert L. Bartholomew, MD, Acting Director, Venereal Disease Division of the Oklahoma State Health Department.



## Wednesday Afternoon, May 15th

- 12:15 p.m. LUNCHEON.** Featured speaker will be James Price, MD, President of the American Academy of Family Physicians.
- 1:15 p.m. PSRO UPDATE.** Robert B. Hunter, MD, member of the Board of Trustees of the AMA, trustee's representative to the AMA Advisory Committee on Professional Standards Review Organizations, and a member of The National Professional Standards Review Council. This latter is the eleven doctor council established by law to advise the secretary of HEW on PSRO. Oklahoma's PSRO status will be discussed by Hillard E. Denyer, MD, Chairman of the Oklahoma Foundation for Peer Review.
- 1:45 p.m. OPHTHALMOLOGY.** Al Lemoine, MD, will present a one-half day session on "Ocular Changes in Diabetes Mellitus," "Ocular Changes in Hematologic Disorder," and "Pathology of the Optic Nerve Head."
- 2:30 p.m. OSMA HOUSE OF DELEGATES.** In the closing session of the House of Delegates elections will be conducted and the house will consider reports from the various reference committees. All final actions on association policy take place at this session.
- 2:45 p.m. SICKLE CELL ANEMIA.** Robert F. Murray, Jr., MD, will discuss "Sickle Cell Anemia, A Challenge." ☐

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**MAJOR MEDICAL INSURANCE  
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**Phil Payne or Rodman A. Frates**  
Administrators

720 NW 50th  
PO Box 18593

405 848-7661

Oklahoma City 73118



# SUMMIT ENTERTAINMENT

## EARLY BIRD PARTY

5:00 p.m. - Sunday, May 12th

New Mercy Hospital and Gaslight Theatre

Medical Summit's Early Bird Party will feature a cocktail reception in the New Mercy Hospital and dinner with a play at Oklahoma City's Gaslight Dinner Theatre. Buses will leave the Skirvin Plaza Hotel at 5:00 p.m. for those physicians who are staying in the downtown area, to arrive at the New Mercy Hospital at approximately 5:30 for a cocktail reception.

At 6:45 the party will adjourn to the Gaslight Dinner Theatre for a prime rib dinner and the delightful play "Fiddler On The Roof." Tickets for the Early Bird Party are \$9.00 per person. ☐

## KEG AND OYSTER PARTY

5:00 p.m. - Monday, May 13th

Myriad Convention Center

Sponsored by Marion Laboratories, the Keg and Oyster Party will feature delicacies from the briney deep and cooling brew. The party will be the proper start for an evening out in one of Oklahoma City's fine restaurants (special arrangements are being made at downtown private clubs for out-of-town physicians. ☐

## INAUGURAL DINNER

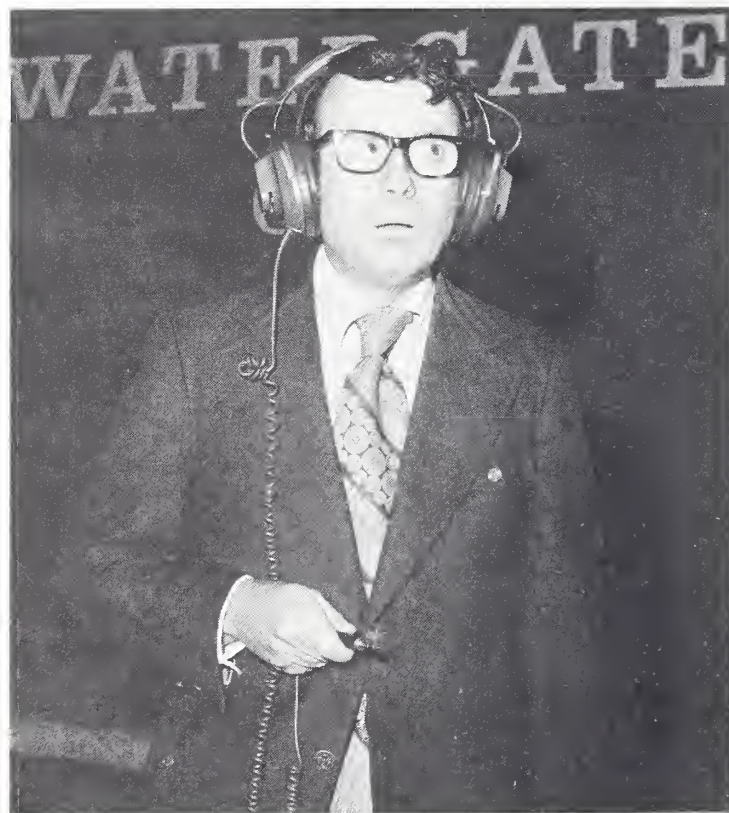
6:30 p.m. - Tuesday, May 14th

Petroleum Club

The Inaugural Dinner honoring outgoing and incoming presidents of OAFP, OSMA and OCCS will be held in the beautiful Petroleum Club atop the Liberty Tower Building. Cocktails and hot hors d'oeuvres will be featured from 6:30 until 7:30 at the President's reception. Dinner will be served at 7:30 featuring a KC Sirloin steak with appropriate wine.

Entertainment during dinner will be furnished by Mr. Mark Russell of Washington, D.C. He is one of the nation's best known political satirists and his presentations in the nation's capitol are relished by congressmen, cabinet members, diplomats, bureaucrats, and other hangers-on.

Tickets for the dinner will be \$14.00 per person, a below-cost price for this super evening! ☐



Mark Russell

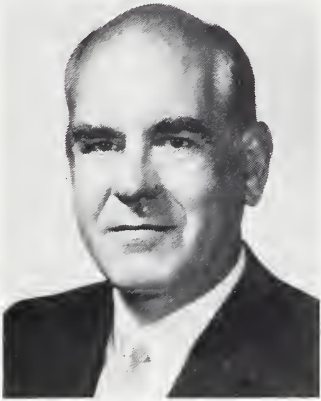


# Summit Luncheon Speakers

Three nationally recognized experts on the socioeconomics of medical care will be luncheon speakers during Oklahoma Medical Summit. Each luncheon will start at 12:15 p.m., Monday through Wednesday, in the Myriad Convention Center's Great Hall North. Tickets are \$5.00 per person per luncheon.

## MONDAY LUNCHEON

### SPEAKER: RUSSELL B. ROTH, MD



**Russell B. Roth, MD**

The Presidency of the American Medical Association is capping a long and distinguished career for this fifty-nine year old Erie, Pennsylvania, Urologist. Prior to his election by acclamation as AMA President-Elect, Doctor Roth had distinguished himself as speaker in the AMA House of Delegates. He served as Vice-Speaker of the House from 1966 until 1969. He has been a member of the Surgeon General's Advisory Committee on the US National Health Survey (1961-64) and is currently a member of the National Advisory Council for Regional Medical Problems and HEW.

## TUESDAY LUNCHEON

### SPEAKER: HARRY SCHWARTZ, PhD

A member of the Editorial Board of the New York Times, Harry Schwartz is best known to the medical profession for his book "Case For American Medicine." In addition, he has published 14 other books and is a visiting Professor of Medical Economics at Columbia University and a distinguished Professor at State University College, New Paltz, New York. Formerly he was a Professor of Economics at Syracuse University and has also taught at New York University, American University and Brooklyn College. He has lectured extensively at Harvard, Princeton, Yale and numerous other universities.



**Harry Schwartz, PhD**

## WEDNESDAY LUNCHEON

### SPEAKER: JAMES PRICE, MD



**James Price, MD**

In private practice in Brush, Colorado, Doctor Price is the current President of the American Academy of Family Physicians. He is a charter Diplomat of the American Board of Family Practice and has served as the Vice-Speaker and Speaker of AAFP Congress of Delegates. He is an assistant Clinical Instructor and Perceptor for the Colorado University School of Medicine and serves as a member of that school's development foundation board. He is a member of the Board of Trustees of the Family Health Foundation of America. His undergraduate work was completed at the University of Colorado, and his MD is from the University of Colorado School of Medicine.

## TICKETS

Tickets for the three luncheons are available from the Oklahoma Medical Summit Office, 601 NW Expressway, Oklahoma City, Oklahoma 73118. They are \$5.00 per person per luncheon. ☐



# AGENDA\*

## House of Delegates Meeting

### ANNUAL MEETING—OPENING SESSION

3:00 p.m., Sunday May 12th, Imperial Ballroom, Skirvin Plaza Hotel

- |                                     |                                   |
|-------------------------------------|-----------------------------------|
| I. Call to Order                    | VII. Board of Trustee's Report    |
| II. Report of Credentials Committee | VIII. Treasurer's Report          |
| III. Introduction of Guests         | IX. Council and Committee Reports |
| IV. Remarks of Speaker              | X. Introduction of Resolutions    |
| V. Nominations for Elections        | XI. Necrology Report              |
| VI. Report of the President         |                                   |

(Reference Committees will meet from 7:30 until 9:30 a.m. on Monday morning, May 13th, in the Myriad Convention Center, Second Floor, West Side.)

### ANNUAL MEETING—CLOSING SESSION

2:30 p.m., Wednesday, May 15th, Myriad Convention Center

- |                                     |                |
|-------------------------------------|----------------|
| I. Call to Order                    | IV. Elections  |
| II. Report of Credentials Committee | V. Adjournment |
| III. Reference Committee Reports    |                |

*\*Condensed version subject to modification*

### OFFICERS TO BE ELECTED

President-Elect (one-year term)  
Vice-President (one-year term)  
Delegate to AMA, position two (two-year term)  
Alternate Delegate to AMA, position two (two-year term)  
Delegate to AMA, position three (two-year term)  
Alternate Delegate to AMA, position three (two-year term)  
Trustees from District VI through IX (three-year term)  
Speaker of the House of Delegates (two-year term)  
Vice-Speaker of the House of Delegates (two-year term)

# Oklahoma State Medical Association

## 1974 Delegates and Alternates

### SOCIETY

### DELEGATE

### ALTERNATE DELEGATE

ALFALFA-WOODS  
ATOKA-BRYAN-COAL  
BECKHAM (Roger Mills)  
BLAINE  
CADDO  
CANADIAN  
CARTER-LOVE-  
MARSHALL

Ed L. Calhoon, MD  
Alfred T. Baker, MD  
Wm. M. Leebron, MD  
Billy D. Dotter, MD  
A. Craig Roberson, MD  
Edgar W. Young, MD

John X. Blender, MD  
W. K. Haynie, MD  
H. K. Speed, MD  
Henry D. Lagan, MD  
E. T. Cook, Jr., MD  
Francis W. Hollingsworth, MD

CHOCTAW-  
PUSHMATAHA  
CLEVELAND-McCLAIN

David D. Rose, MD  
Michael W. Brown, MD

James V. Miller, MD  
Fred L. Medcalf, MD

Bill E. Woodruff, MD  
William T. Stone, MD  
James B. Silman, MD  
Hayden H. Donahue, MD  
Robert R. Sullivan, MD  
Robert R. Hillis, MD  
Jack D. Honaker, MD  
Samuel C. Jack, MD

(Not reported)  
W. George Long, MD  
Edwin G. Horne, Jr., MD  
Jim L. Haddock, MD  
Virgil Simmering, MD  
Walter Wicker, MD  
Robert H. Drewry, MD  
Robert L. Shore, MD

COMANCHE-COTTON  
TILLMAN

COOKSON HILLS  
(Cherokee, Adair &  
Sequoyah)  
CRAIG-DELAWARE-  
OTTAWA  
CREEK  
CUSTER  
EAST CENTRAL  
(Muskogee, Wagoner  
& McIntosh)

Clifford A. Traverse, MD

Omar J. Morgan, MD

David Carson, MD  
(Not reported)  
J. Harold Tisdal, MD

Ollie DeHart, MD  
(Not reported)  
John M. Huser, MD

Tom S. Gafford, MD  
Ann K. Kent, MD  
Maurice C. Gephardt, MD  
Edward Fite, MD  
Robert D. Shuttee, MD  
Joseph W. Stafford, MD  
Joe B. Jarman, Jr., MD  
James H. Lindsey, MD  
B. C. Chatham, MD  
Phillip N. Kingery, MD  
(Not reported)  
C. L. Tefertiller, MD  
David Fried, MD  
(Not reported)  
E. C. Yearly, MD  
Ray V. McIntyre, MD  
Malcolm Bridwell, MD  
R. L. Winters, MD  
Wm. I. Jones, MD  
Robert Ringrose, MD  
Thomas E. Rhea, MD  
(Not reported)

(Not reported)  
(Not reported)  
(Not reported)  
(Not reported)  
Frank Adelman, MD  
Earl M. Robinson, MD  
Gene Stunkle, MD  
John W. Ellis, MD  
C. R. Gibson, MD  
Wade Norman, MD  
(Not reported)  
(Not reported)  
(Not reported)  
(Not reported)  
E. Edwin Fair, MD  
Paul J. Ottis, MD  
Jim C. Couch, MD  
Robert L. Hampton, MD  
Harold T. Baugh, MD  
(Not reported)  
T. D. Howard, MD  
(Not reported)

GARFIELD

GARVIN  
GRADY  
GREER-HARMON  
HUGHES-SEMINOLE  
JACKSON

(Not reported)  
Noel E. Miller, MD  
Donald D. Albers, MD  
Martin H. Andrews, MD  
Charles N. Atkins, MD  
John A. Blaschke, MD  
Karl K. Boatman, MD  
Kent Braden, MD

(Not reported)  
Thomas W. Coale, MD  
Stephen E. Acker, MD  
Schales L. Atkinson, MD  
A. S. Bailey, MD  
Paul A. Barrett, MD  
Wm. G. Bernhardt, MD  
Charles D. Bodine, MD

JEFFERSON  
KAY-NOBLE  
KINGFISHER  
KIOWA-WASHITA  
LeFLORE-HASKELL  
LINCOLN  
LOGAN  
McCURTAIN  
MURRAY  
NORTHWEST  
Beaver, Dewey, Ellis,  
Harper & Woodward)  
OKFUSKEE  
OKLAHOMA



OKMULGEE  
 OSAGE  
 PAYNE-PAWNEE  
 PITTSBURG (Latimer)  
  
 PONTOTOC (Johnston)  
  
 POTTAWATOMIE  
  
 ROGERS-MAYES  
 STEPHENS  
 TEXAS-CIMARRON  
 TULSA

WASHINGTON-  
 NOWATA

Jerry Bressie, MD  
 Irwin H. Brown, MD  
 R. B. Carl, MD  
 Leroy Carpenter, MD  
 Wm. R. Cleaver, MD  
 Chas. E. Delhotal, MD  
 John W. DeVore, MD  
 John W. Drake, MD  
 Arthur F. Elliott, MD  
 Warren Felton, II, MD  
 Thomas H. Henley, MD  
 Wm. E. Hood, Jr., MD  
 Edmond H. Kalmon, Jr., MD  
 Felix R. Kay, MD  
 Daniel M. Lane, MD  
 L. O. Laughlin, MD  
 Robert A. McLaughlin, MD  
 Edward R. Munnell, MD  
 James B. Pitts, Jr., MD  
 Orville L. Rickey, Jr., MD  
 Clarence Robison, MD  
 W. W. Sanger, MD  
 Arthur E. Schmidt, MD  
 Armond H. Start, MD  
 W. David Stuart, MD  
 Stephen Tkach, MD  
 Marion C. Wagnon, MD  
 Ken W. Whittington, MD  
 Neil W. Woodward, MD  
 F. T. Hubbard, MD  
 Richard F. Harper, MD  
 Tim K. Smalley, MD  
 George M. Brown, Jr., MD  
 Joe W. McCauley, MD  
 Richard M. Taliaferro, MD  
 Orange M. Welborn, MD  
 Roy O. Kelly, Jr., MD  
 Leon D. Combs, MD  
 Peter Sarfatis, MD  
 (Not reported)  
 (Not reported)  
 Bernard E. Guenther, MD  
 Frank A. Clingan, MD  
 C. E. Woodard, MD  
 Jerry Sisler, MD  
 C. S. Lewis, Jr., MD  
 Floyd F. Miller, MD  
 Robert L. Imler, Jr., MD  
 Robt. M. Shepard, Jr., MD  
 Lynwood Heaver, MD  
 Henry H. Modrak, MD  
 Robert K. Endres, MD  
 R. W. Goen, MD  
 Wm. E. Hall, MD  
 Hall Ketchum, MD  
 Donald F. Mauritson, MD  
 Edward K. Norfleet, MD  
 James E. White, MD  
 Roger V. Haglund, MD  
 Richard E. McDowell, MD  
 Rollie E. Rhodes, Jr., MD  
 E. N. Lubin, MD

John R. Reid, Jr., MD  
 Carl H. Guild, MD  
 Vernon M. Lockard, MD

Richard H. Bottomley, MD  
 Walter L. Bowlan, MD  
 Myron A. Cordum, MD  
 Ernest R. Daffer, MD  
 Leonard R. Diehl, MD  
 Richard G. Dotter, MD  
 James R. Geyer, MD  
 James S. Grim, MD  
 James F. Hammarsten, MD  
 James W. Hampton, MD  
 Wm. D. Hawley, MD  
 Perry A. Lambird, MD  
 Bertha M. Levy, MD  
 Robert D. Lindeman, MD  
 James E. Mays, Jr., MD  
 John F. Montroy, MD  
 Wm. L. Parry, MD  
 A. Stanley Porter, MD  
 Tony G. Puckett, MD  
 Herbert P. Reinhardt, MD  
 Chas. W. Robinson, Jr., MD  
 Joseph B. Ruffin, MD  
 S. S. Sanbar, MD  
 S. R. Shaver, MD  
 Marcus B. Shook, MD  
 L. D. Threlkeld, MD  
 S. Fulton Tompkins, MD  
 James B. Wise, MD  
 C. Jack Young, MD  
 T. C. Alexander, MD  
 John Hudson, MD  
 Lanny F. Trotter, MD  
 Hartzell V. Schaff, MD  
 Robert M. Adams, MD  
 David C. Ramsay, MD  
 Clarence P. Taylor, MD  
 Jake Jones, MD  
 W. C. Click, MD  
 Johnny J. Morgan, MD  
 (Not reported)  
 (Not reported)  
 James C. Smith, Jr., MD  
 Walter H. Gary, MD  
 Milton L. Berg, MD  
 Leonard H. Brown, MD  
 R. Wayne Neal, MD  
 Manuel Brown, MD  
 Richard F. Tenney, MD  
 Robt. G. Perryman, MD  
 Joe E. Tyler, MD  
 Victor Ray Neal, MD  
 Delmar L. Gheen, Jr., MD  
 Wm. J. O'Meilie, MD  
 James D. Green, MD  
 Matthew B. Moore, MD  
 Thomas L. Ashcraft, MD  
 James K. Boyd, MD  
 Edward W. Jenkins, MD  
 Robt. L. Anderson, MD  
 Wm. B. Scimeca, MD  
 Roger E. Wehrs, MD  
 Wm. G. Mays, MD

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WOMAN'S AUXILIARY  
to the  
OKLAHOMA STATE MEDICAL ASSOCIATION

# ANNUAL CONVENTION PROGRAM

May 12th, 13th, 14th, 15th, 1974

Skirvin Plaza Hotel

Oklahoma City, Oklahoma

## PLEDGE

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

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Walter E. Brown, MD  
Floyd F. Miller, MD  
Scott Hendren, MD  
Daniel R. Storts, MD

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Mrs. Virgil Ray Forester  
Mrs. William M. Leebron



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*President*  
*Woman's Auxiliary to the*  
*Southern Medical Association*



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*Oklahoma State Medical Association*  
*Recording Secretary*  
*Woman's Auxiliary to the*  
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*Woman's Auxiliary to the*  
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*President-elect*  
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*Oklahoma State Medical Association*



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*Treasurer-elect*  
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*Oklahoma State Medical Association*



## GENERAL INFORMATION

### REGISTRATION

Crystal Room, Mezzanine  
Skirvin Plaza Hotel

Sunday, May 12th .....12:00 noon-4:00 p.m.  
Monday, May 13th .....8:30 a.m.-5:00 p.m.  
Tuesday, May 14th .....8:30 a.m.-5:00 p.m.  
Wednesday, May 15th .....8:30 a.m.-12:00 noon

### HOSPITALITY

Crystal Room, Mezzanine

This room will be open during registration hours, Sunday, Monday, Tuesday and Wednesday, for the convenience of guests. Coffee and iced tea will be available during open hours. Rolls will be available, complimentary, from 8:30 a.m.-10:00 a.m. Monday, Tuesday, and Wednesday, courtesy of the Convention Committee.

### DOCTORS' DAY EXHIBITS

Crystal Room, Mezzanine

Monday, Tuesday and Wednesday

Mrs. M. Thomas Buxton, Chairman

### OSMA ADVISORS

Walter E. Brown, MD, Tulsa  
Scott Hendren, MD, Oklahoma City  
Floyd F. Miller, MD, Tulsa  
Daniel R. Storts, MD, Tulsa

### CONVENTION COMMITTEE

CHAIRMAN: Mrs. Robert S. Ellis

CO-CHAIRMAN: Mrs. Galen P. Robbins

Credentials .....Mrs. Donald D. Albers  
Decorations .....Mrs. Johnny A. Blue  
Gifts .....Mrs. Robert S. Ellis  
Luncheon .....Mrs. Edmond H. Kalmon, Jr.  
Memorial .....Mrs. Ralph E. Payne  
Page .....Mrs. Warren Gwartney  
Public Relations .....Mrs. Virgil Ray Forester  
Registration and

Hospitality .....Mrs. Kenneth W. Whittington  
Showcase Tour .....Mrs. John H. Carney  
Tickets .....Mrs. Louis S. Frank  
Timekeeper .....Mrs. Richard E. Witt  
Tour Transportation .....Mrs. C. Jack Young  
Ladies Tennis .....Mrs. Ferris Coggins

### PAST-PRESIDENTS' BREAKFAST

Tuesday, May 14th, Executive Suite, 8:00 a.m.

Mrs. Richard Clay, Chairman

### RECEPTION FOR MEMBERS-AT-LARGE COUNTY PRESIDENTS AND COUNTY PRESIDENTS-ELECT

Presidential Suite, 3:30 p.m.-4:30 p.m.

Mrs. William Renfrow . . . Chairman

Mrs. George Krietmeyer

Tuesday, May 14th

### SPECIAL ADDED ATTRACTIONS

SUNDAY, MAY 12th 1974

COCKTAIL PARTY .....New Mercy Hospital

5:30 p.m.-6:45 p.m.

SUNDAY, MAY 12th, 1974

"EARLY BIRD PARTY", Gaslight Theatre  
7:00 p.m.

MONDAY, MAY 13th, 1974

DESIGNER'S SHOWCASE HOUSE TOUR

(buses leave Skirvin at 10:00 a.m.

return to Skirvin at 12:00 noon)

SUMMIT LUNCHEON, 12:15 p.m., Myriad honoring  
Russell B. Roth, MD, President, AMA

KEG AND OYSTER PARTY, 5:15 p.m., Myriad

TUESDAY, MAY 14th, 1974

"MAY DAY AWARDS" LUNCHEON (Auxiliary)  
with INFORMAL MODELING

by Balliets, Skirvin Plaza, 12:30 p.m., Honoring  
Mrs. Willard C. Scrivner, President, Woman's  
Auxiliary to the American Medical Association.

A.M.A.-E.R.F. AWARDS presented by Robert C.  
Bird, MD, Dean, College of Medicine, University  
of Oklahoma.

Membership and Doctors' Day Award Presenta-  
tions. (tickets MUST be purchased by Friday,  
May 10th)

Inaugural Dinner, 6:30 p.m., Petroleum Club—  
Mark Russell, Entertainer

WEDNESDAY, MAY 15th, 1974

OWENS GALLERY OF WESTERN ART

Liberty Bank Galleria, 10:00-11:30 a.m. (West-  
ern print to be given to registered lady)

SUMMIT LUNCHEON, Myriad, 12:15 p.m. Hon-  
oring James G. Price, MD, President, AAFP

FREE DEMONSTRATIONS FOR LADIES

Crystal Room, Skirvin Plaza

Monday, May 13th, 2:30-3:30 p.m.

Tuesday, May 14th, 10:30-11:30 a.m.

SPEED READING COURSE, Room 18, Myriad

Fee: \$50.00 for 9 hours.

Sunday, May 12th .....9:00 a.m. to 12:00 noon

Monday, May 13th .....4:00 p.m. to 6:00 p.m.

Tuesday, May 14th . . . . . 4:00 p.m. to 6:00 p.m.  
Wednesday, May 15th . . . . . 4:00 p.m. to 6:00 p.m.

VERBAL COMMUNICATIONS SEMINAR, Myriad  
Fee: \$12.00  
Wednesday, May 15th . . . . . 9:00 a.m.-12:00 noon  
Repeated at . . . . . 1:00 p.m. to 4:00 p.m.

## PROGRAM

### MONDAY, May 13th, 1974

8:30 a.m.-5:00 p.m. REGISTRATION AND HOSPITALITY, Crystal Room, Skirvin Plaza  
1:00 p.m.-2:30 p.m. NURSES LOAN FUND, Presidential Suite, Skirvin Plaza  
2:30 p.m.-4:30 p.m. PRE-CONVENTION BOARD MEETING, Regency Room, Skirvin Plaza, All Officers, Chairmen, Councilors, Councilors-elect, County Presidents and Presidents-elect are expected to attend. Refreshments will be served.  
5:15 p.m. KEG AND OYSTER PARTY, Myriad

### TUESDAY, MAY 14th, 1974

8:00 a.m. PAST-PRESIDENTS' BREAKFAST, Executive Suite, Skirvin Plaza, Mrs. Richard Clay, Chairman  
8:30 a.m.-5:00 p.m. REGISTRATION AND HOSPITALITY, Crystal Room, Skirvin Plaza  
9:00 a.m. HOUSE OF DELEGATES, Woman's Auxiliary to the Oklahoma State Medical Association, Skirvin Plaza. Mrs. Daniel R. Storts, President, Woman's Auxiliary to the Oklahoma State Medical Association, presiding.  
CALL TO ORDER: Mrs. Daniel R. Storts, Tulsa

INVOCATION: Mrs. Ed Calhoon, Beaver

WELCOME: Mrs. James P. Bell, President-Elect, Woman's Auxiliary to the Oklahoma County Medical Society

RESPONSE: Mrs. Floyd F. Miller, President, Woman's Auxiliary to the Tulsa County Medical Society.

GREETINGS: C. Riley Strong, MD, El Reno, President, Oklahoma State Medical Association.

INTRODUCTION OF SPECIAL GUESTS: Mrs. Storts

Mrs. Willard C. Scrivner, East St. Louis, Illinois, President, Woman's Auxiliary to the American Medical Association; Mrs. W. Nash Thompson, Stuart, Virginia, President,

Woman's Auxiliary to the Southern Medical Association.

ROLL CALL BY COUNTIES: Mrs. Ronald F. Gates, Tulsa, Recording Secretary.

REPORT OF CREDENTIALS CHAIRMAN: Mrs. Donald D. Albers, Oklahoma City

READING AND ADOPTION OF MINUTES: Mrs. Gates

CONVENTION ANNOUNCEMENTS: Mrs. Robert S. Ellis, Oklahoma City

TREASURER'S REPORT: Mrs. James Haddock, Norman, Treasurer

GUEST SPEAKER: Mrs. W. Nash Thompson, President, Woman's Auxiliary to the Southern Medical Association.

All Officers, Chairmen and Presidents' reports will be very brief. Full reports have been printed for distribution to Delegates.

### REPORTS OF ELECTED AND APPOINTED OFFICERS:

President: Mrs. Storts

President-elect: Mrs. John W. Williams, Enid

First Vice-President: Mrs. William B. Renfrow, Oklahoma City

Second Vice-President: Mrs. George R. Krietmeyer, Tulsa

Treasurer-elect: Mrs. Neil B. Kimerer, Oklahoma City

Corresponding Secretary: Mrs. Boyd O. Whitlock, Tulsa

Editors, "S.P.W.": Mrs. Adolph N. Vammen and Mrs. Leonard Kishner, Tulsa

Editor, "Journal" page: Mrs. Richard B. Price, Oklahoma City

Historian: Mrs. J. William McDoniel, Chickasha

Parliamentarian: Mrs. Port E. Johnson, Muskogee

### REPORTS OF COMMITTEE CHAIRMEN:

A.M.A.-E.R.F.: Mrs. Scott Hendren, Oklahoma City

W.A. S.A.M.A.: Mrs. Virgil Ray Forester, Oklahoma City

Finance: Mrs. James L. Haddock for Mrs. J. Hartwell Dunn, Oklahoma City

Nurses Loan Fund: Mrs. Alfred T. Baker, Durant

Doctors' Day: Mrs. M. Thomas Buxton, Oklahoma City



Legislation: Mrs. Gerald C. Zumwalt, Sapulpa and Mrs. Dan E. Woodson, Oklahoma City

Nominating: Mrs. John W. Williams

Procedure Guide: Mrs. George Miller, Tulsa

Health Services:

Safety: Mrs. Donald R. Bergman, Tulsa

Children & Youth: Mrs. Jerrie L. Bressie, Oklahoma City

International Health: Mrs. Michael W. Brown, Ardmore

Health Education:

Mental Health: Mrs. A. B. Wight, Enid

Nutrition: Mrs. Zia Vargha, Tulsa

Health Careers: Mrs. Willard Aronson, Oklahoma City

IDEAS EXCHANGE BY COUNTY PRESIDENTS (two minutes):

Atoka-Bryan-Coal . . . . Miss Opal Haynie Carter-Love-

Marshall . . . . . Mrs. Robert C. Troop  
Cleveland-McClain .. Mrs. James S. Wall Comanche-

Cotton-Tillman ... Mrs. F. John Lashley  
Custer . . . . . Mrs. James R. Rhymer

East Central .... Mrs. Robert B. Brownell  
Garfield . . . . . Mrs. John H. Walsh

Grady-Caddo .. Mrs. William S. Harrison  
Kay-Noble . . . . Mrs. Carter W. Mathews

Oklahoma . . . . . Mrs. John W. Records  
Okmulgee . . . . . Mrs. W. M. Haynes

Pittsburg . . . . . Mrs. Karl F. Sauer  
Pontotoc-Johnston .. Mrs. Carl R. Osborn

Pottawatomie . . . . Mrs. Roy C. Kelly  
Stephens . . . . . Mrs. Richard A. Ellis

Tulsa . . . . . Mrs. Floyd F. Miller  
Washington-

Nowata .... Mrs. Richard S. C. Grisham

UNFINISHED BUSINESS: Bylaws Revisions:  
Mrs. Storts for Mrs. William M. Leebron, Elk City

NEW BUSINESS:

ELECTIONS OF 1974-75 OFFICERS

RESOLUTIONS: Mrs. George Miller, Tulsa

ANNOUNCEMENTS:

MEMORIAL SERVICES: Mrs. Ralph E. Payne, Oklahoma City

ADJOURNMENT

12:30 p.m. "MAY DAY AWARDS" LUNCHEON with INFORMAL MODELING BY BALLIETS

Skirvin Plaza. Husbands are invited to attend. Tickets must be purchased by Friday, May 10th.

HONORING: Mrs. Willard C. Scrivner, President, Woman's Auxiliary to the American Medical Association.

Introduction of Special Guests: Mrs. Scrivner; Mrs. W. Nash Thompson, President, Woman's Auxiliary to the Southern Medical Association and Doctor Thompson; Robert C. Bird, MD, Dean, College of Medicine, University of Oklahoma Health Sciences Center.

Invocation: Mrs. Virgil Ray Forester, Past-President.

Introduction of Guests

Speaker: Mrs. Scrivner

Presentation of Awards:

A.M.A.-E.R.F.: Robert Bird, MD

A.M.A.-E.R.F. Ajems pendant drawing:

Mrs. Scott Hendren

Membership Awards

Doctors' Day Awards

Installation of 1974-75 Officers: Mrs. Scrivner

Presentation of Gavel and Pin

Installation Speech: Mrs. John W. Williams, President, Woman's Auxiliary to the Oklahoma State Medical Association

3:30 p.m.-4:30 p.m. RECEPTION honoring MEMBERS-AT-LARGE, COUNTY PRESIDENTS AND COUNTY PRESIDENTS-ELECT.

Presidential Suite, Skirvin Plaza. Mrs. William B. Renfrow and Mrs. George R. Krietmeyer hostesses.

6:30 p.m. Cocktails

7:30 p.m. INAUGURAL DINNER, Petroleum Club, Mark Russell, Speaker

WEDNESDAY, MAY 15th, 1974

8:30 a.m. POST CONVENTION BOARD MEETING. Executive Suite, Skirvin Plaza. Mrs. John W. Williams, President, presiding. All Officers, Chairmen, Councilors, Councilors elect, County Presidents and Presidents-elect are expected to attend.

10:00 a.m. OWENS GALLERY OF WESTERN ART, Liberty Bank Galleria. Coffee and roll will be served. Western print will be given to registered lady.

2:30 p.m. CLOSING SESSION, OSMA House of Delegates, Myriad. Senator Russel Long Louisiana, Speaker. Ladies invited to attend

## DEATHS

### FLOYD GRAY, MD 1895-1974

Floyd Gray, MD, 79-year old, Oklahoma City obstetrician and gynecologist, died March 20th, 1974. Doctor Gray was a native of Mountain View, Oklahoma and a 1928 graduate of the University of Oklahoma College of Medicine, where he later became Associate Professor of Obstetrics and Gynecology. He was a member of the Central State OB-GYN Association and a Life Member of the OSMA.

### HENRY C. TRASKA, MD 1917-1974

A well-known Oklahoma City obstetrician and gynecologist, Henry C. Traska, MD, died February 16th, 1974. Born in College Point, New York, Doctor Traska was graduated from the University of Oklahoma College of Medicine in 1943. Following practice in Hennessey, he moved to Oklahoma City where he remained until his death. Doctor Traska held a fellowship for research from the American Cancer Society.

### CHESTER A. PAVY, MD 1882-1974

Chester A. Pavy, MD, 91, retired physician who was named "Doctor of the Year" by Tulsa County Medical Soc-

iety Auxiliary in 1961, died March 8th, 1974. Specializing in otolaryngology, Doctor Pavy retired in 1963 after practicing in Tulsa for 33 years.

A native of Greensburg, Indiana, Doctor Pavy received his medical degree from the Indiana University School of Medicine in 1911. He had served with the Medical Corps during World War I.

### ALPHA McADAMS WILLIAMS, MD 1893-1974

A Shawnee physician for over 50 years, Alpha McAdams Williams, MD, died March 14th, 1974. A native of Texas, Doctor Williams was graduated from the University of Oklahoma School of Medicine in 1921. She practiced in Tecumseh for a short while before establishing her practice in Shawnee. Her specialty was ophthalmology and otolaryngology.

### MRS. THOMAS BOYD TURNER 1877-1974

Mrs. Thomas Boyd Turner, 96, widow of the late Thomas Boyd Turner, MD, died March 15th, 1974. Born in Morrilton, Arkansas, Mrs. Turner was graduated from Galloway College in Searcy, Arkansas. She and Doctor Turner lived in Hoyt, Indian Territory, and Stigler, Oklahoma where he practiced from 1901 until his death in 1949. She was the mother of Mrs. James P. Bell, wife of James P. Bell, MD, Oklahoma City physician. □

## TELEPHONE MESSAGE

While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:

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## American Medical Students Abroad

Many people, among them numerous physicians, assume that all qualified American applicants for admission to medical school, particularly in their home state, will eventually be accepted. Surprisingly this is not so. Half of the applicants who have successfully completed their undergraduate training at an accredited college, have passed the appropriate admission tests and fulfilled all other requirements for admission, are rejected. This is due to a lack of space at the present schools and is happening in the face of a demonstrated need for physicians, particularly in the fields of family care and general practice. It has been estimated that more than 100 additional medical schools of average size would be necessary to make room for the present number of qualified, but rejected American candidates.

It can be assumed that the number of American applicants during the next years is still going to rise. In previous editorials we have pointed out that the existing gap in the number of needed physicians is being filled in the most inexpensive, but least desirable way, *ie* by depriving other countries of their physicians. Among these are some of the most underprivileged states where physicians are so badly needed. We are of course familiar with the fact that the advanced West-European nations and the US fill their least desirable vacancies on the labor market by immigrating or migratory workers from impoverished countries. But why should qualified Americans be refused access to a field which is intellectually, spiritually and economically so rewarding and therefore so desirable and desired by the young college graduate? Why should we deprive him of this gratifying lifetime experience in an area of endeavor where he is so badly needed?

Thus the question arises, what happens to the American rejectees? Are they completely lost for the broad area of health care? On the basis of existing, but somewhat tentative data we may assume that about half of the rejected candidates embark on different careers. The other half may enter health related and paramedical professions, where they usually work out quite satisfactorily. Others enroll in graduate school, particularly in the biomedical sciences and obtain an advanced degree there. Some of these,

particularly after they have made good in their training, are given a second chance and are accepted in an American medical school. Others are accepted in a medical school after they have obtained or while they are working on their PhD degree. They usually have been quite successful in an academic career as researchers and/or teachers. This again proves how unreliable the evaluation of the medical school admissions committees can be. As an example, it has been pointed out that Dr. Julius Axelrod, a biochemist and a 1970 Nobel Prize winner, is a rejectee from American medical schools.

But the most determined of the rejectees go to a foreign medical school. In this editorial we are particularly concerned with this group. What is their number? It has been estimated that there are roughly 4,000 Americans enrolled in medical schools outside the US, particularly in Mexico, Italy and Spain. Among these, two schools stand out by the large number of American enrollees, Guadalajara in Mexico (936 American medical students in 1971), and Bologna in Italy. Few Americans are accepted in France or Belgium. The paradox that we are exporting American medical students and importing foreign physicians should not be lost on the authorities.

The prerequisites for admission to foreign schools are essentially the same as in this country, but to this has to be added mastery of the language of the country, which may require one semester to a year. The time for admission to the foreign school until graduation and granting of a medical degree varies, but generally amounts from five to seven years. In Mexico this includes an internship and an additional year of social service practice. If all these hurdles are overcome, the candidate is entitled to take the examination of the Educational Council for Foreign Medical Graduates (ECFMG). In most states in the US the passing of this test is required for an accredited internship or residency. This is to be followed by a state licensing board examination, the passing of which finally authorizes the physician to practice in this state. State requirements for licensing are somewhat variable, depending on the needs for



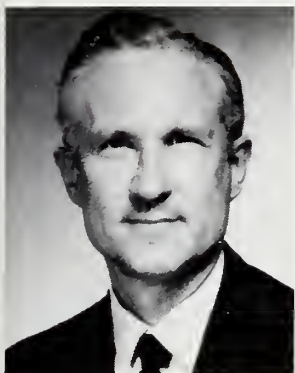
physicians. Thus the American graduate of a foreign medical school may spend one or two more years than he would have, had he been accepted in an American school. The cost of tuition varies from \$300 in Italy to \$4000 per year in Guadalajara. To this has to be added the cost of language courses, special tutoring, laboratory fees and textbooks in addition to living and traveling expenses. No scholarships or federally backed loans are available. It is of course difficult to evaluate the psychological trauma and hardships to which the rejected American medical student is exposed in a strange culture and environment, using a foreign language and facing not rarely hostility on the part of the native student. How are our American students faring at these foreign medical schools? Due to the difficulties discussed, 50% of American students in foreign schools drop out, mainly in the first years of their course, and only about one-fourth successfully complete the training program.

What induces foreign universities to accept American medical students? In addition to economic reasons (tuition for an American is of course higher than for the native student), the older European schools still practice a philosophy, which originated in medieval and Renaissance times, *ie* that the universities are extra-territorial guardians of culture and the pursuit of studies, open to anybody in the historical tradition of Salerno, Padua, Paris, and Leyden. This liberal attitude also is expressed by the fact that attendance at lectures and laboratories is voluntary. On the other hand the quality of pre-clinical and medical training in the usually under-financed foreign schools is quite often inferior to that offered by American medical schools. The teaching is mostly didactic and clinical exposure and training at the bedside is sparse. Facetiously, but not quite unreasonably one might argue that if the rejected, but qualified American medical students were allowed to sit on the steps of American lecture halls and look over the shoulder of accepted medical students in the laboratories or at the bedside, they might learn more than at some foreign school. The type of training offered by the latter makes it harder for the candidate to subject himself to the ECFMG examination, which is of course oriented toward the American medical school programs. In addition it requires the American

foreign graduate to switch to the medical jargon of the English language and a style of examination (multiple choice test) to which he is not accustomed by his foreign experience. Nevertheless, in 1972, 472 American candidates, who were graduates of foreign medical schools, passed the ECFMG examination, *ie* 36% of those that took it, and in 1972, 240 state licenses were issued to American graduates of foreign medical schools. The illogical approach to the problem of the American foreign medical graduate (FMG) has of course not been lost on many institutions and individuals of influence. The parents themselves have formed a Parent's League for American Students of Medicine (PLASMA), and have brought the plight of the student to the attention of the authorities. Measures have been taken by various states to integrate the American FMG earlier into the American medical educational system. Various pathways have been suggested and partially realized. Some students are admitted with advanced standing to American medical schools. A coordinated transfer system (Cotrans) has been established by the Association of American Medical Colleges and the so-called "Fifth Pathway" has been opened up which allows the American FMG to substitute for the foreign internship and the often required social obligation, a clinical, supervised clerkship, preceding entrance into an accredited internship without having to take the ECFMG examination. But only 12 schools are cooperating in this program at the present time.

Summarizing this and previous discussions, the final answer lies in the US and state government authorities becoming aware of the necessity to meet its own health manpower needs and thus avoid the unethical and unsatisfactory demand for the extremely large number of foreign trained physicians, including Americans, to fill the vacuum. This in no way precludes the admission of FMG's to the US, particularly from those countries that can spare them and that offer a good biomedical education. They can and will be utilized in practice, teaching, and research. It likewise does not imply that more than 100 additional medical schools would be required, as one JAMA editorial suggests. The present student/faculty ratio might well be increased without loss of quality by recourse to modern learning devices and by making available the vast resources of accredited community hospitals and practicing physicians for bedside teaching. *Ernest Lachman, MD* □





To my colleagues of our State Association, I want to express my deep gratitude for the honor you do me in electing me to this high office. I find myself exhilarated by our past accomplishments together and at the same time humbled by the awe-

some charges you have given me. I have only to recall the fine Presidents who have gone before me to realize that my commitment must be great. We have a great Association and I am very proud of it. My six years on the Board of Trustees and in the House of Delegates revealed to me that I was among a group of men working sincerely, conscientiously, tirelessly and compassionately for the welfare of the public and stability of their profession. I must admit that this was a somewhat disturbing experience for one who for years had wanted "only to practice Orthopedic Surgery and avoid the politics of medicine." This experience converted me and I hope that it does many of you.

It will be my purpose to deliberate with caution, act with decision, yield with grace (Lord, it will be hard!) and oppose with strength (much easier!).

I can find no other period in the history of our profession in this country when we have been in greater jeopardy, not for ourselves alone, but, more importantly, for the welfare of our patients. What the politicians fail to realize is that when they place restrictive controls on the medical profession they are at the same time being restrictive to the patients, the very ones they propose to help.

I am indeed weary of their contention that good medical care is a "right" while essentially ignoring other equally important factors in the sustaining of life such as proper and adequate food, good clothing, satisfactory housing and good legal representation. Only the physician and his patients are being discriminated against, while no such repressive and constrictive controls are placed on others.

When federal Peer Review was proposed for possibly some anticipated degree of increased efficiency of utilization and cost control, it seemed only proper that we should cooperate. The government promised that pre-admission certification would be late in the program, if actually it was to be effected at all, but immediately and before other regulations were promulgated, those in H.E.W. attempted to impose pre-certification and this gave the lie to the whole program. Their program even included punitive action against physicians and our patients were again to be victimized by inadequate care, just as they were when big promises for Extended Care under the Medicare program were professed and then later withheld. Again, big government has proved faithless and has forced us to respond and react. This we did with some degree of effect, although only the future will reveal how permanent this effect will prove to be. Only one thing is really important to us as doctors and that is the provision of adequate, high quality medical care for our patients and this the government has proven it does not intend. It could not give it, even if it wanted to. Only the Medical Profession has given it in the past; only the Medical Profession is able to give it now; only the Medical Profession can give it in the future.

*J. L. Richardson, M.D.*

J. L. Richardson, MD

P.S. Regarding PSRO, OSMA activities and policy are reflected in the reports beginning on page 219 of this issue.



# Hodgkin's Disease

## A Pathological, Clinical Review of All Cases Treated in the Radiation Oncology Department,

Saint Francis Hospital, Tulsa, Oklahoma,  
From September, 1968 to October, 1973

### MATERIALS AND METHODS

BARBARA C. BROOKS, MS  
ROBERT G. ELLIS, MD  
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DAVID S. GOODEN, PhD

*Hodgkin's Disease is proving to be curable with modern radiation techniques. A retrospective analysis of the patients treated in a moderate sized general hospital over the last five years is presented and the results compared to those of large treatment centers.*

### INTRODUCTION

In September of 1968 a Theratron 80 Cobalt 60 unit was installed at Saint Francis Hospital, Tulsa, Oklahoma. At this time, five years later, it was considered appropriate to evaluate the results of treatment of the diseases felt to be potentially curable by radiation therapy and to compare our results with those of other institutions. We are hopeful that this study will provide guidance in the selection of future treatment protocols. The initial disease selected for review was Hodgkin's Disease, which is presented here.

From the Saint Francis Hospital and The William K. Warren Medical Research Center, Inc., Tulsa, Oklahoma 74136

### Group Characteristics

The group of patients for this study consisted of all patients treated for Hodgkin's Disease in the Radiation Oncology Department of Saint Francis Hospital from September, 1968 to October, 1972 (with follow-up continuing through October, 1973). The group contained one Mexican American and 31 Caucasian patients. The general socioeconomic status was that of middle class. The patients ranged in age from 11 to 86 years. There were 15 males and 17 females.

### Histology

All histologic material was reviewed by the Pathology Department of Saint Francis Hospital. Confirmation of the diagnosis of Hodgkin's Disease was made and the histopathology was classified according to the Rye classification utilizing the criteria of Lukes and Butler<sup>9</sup>, ie, lymphocyte predominance, nodular sclerosing, mixed cellularity, and lymphocyte depletion.

### Staging

All charts were reviewed to verify the original staging as correct. If there was a conflict between the original staging and the information contained in the chart, a new staging ac-

cording to the physical and clinical findings described in the chart before therapy was instituted was applied. The cases were staged according to the Rye classification<sup>13</sup> as follows:

Stage I—disease in lymph nodes and limited to one anatomic region or to two contiguous anatomic regions on the same side of the diaphragm (spleen, thymus and Waldeyer's ring are considered lymph nodes for purposes of staging).

Stage II—disease limited to lymph nodes in more than two anatomic regions or in two non-contiguous regions on the same side of the diaphragm.

Stage III—disease on both sides of the diaphragm but limited to involvement of lymph nodes, spleen, or Waldeyer's ring.

Stage IV—involvement of the bone marrow, lung parenchyma, pleura, liver, bone, skin, kidneys, gastrointestinal tract, or any organ in addition to the lymphoid structures.

Letters A and B were employed after the staging number to designate the presence or absence of constitutional symptoms, *ie*, fever, night sweats, and weight loss. The letter "A" designates the absence of clinical symptoms and the letter "B" designates the presence of clinical symptoms.

#### *Treatment Method*

The majority of patients, unless they were Stage IV and being treated palliatively, were treated with extended fields. A mantle field was usually utilized for treatment above the diaphragm. An inverted Y or separate periaortic and pelvic fields were utilized for treatment below the diaphragm. Most Stage I and II patients were not treated on the uninvolved side of the diaphragm. Stage III patients were treated with total nodal irradiation. Dose levels were usually 3,600 to 4,000 rads delivered in four to six weeks. Stage IV patients and some Stage III patients were treated in conjunction with chemotherapy. Stage I, II and III patients who failed with radiation therapy were subsequently treated in the majority of instances with chemotherapy.

#### *Statistical Method*

Survival was calculated by the actuarial life table method. The actuarial method utilizes all survival information accumulated up to the closing date of the study, and describes the manner in which the patient group was de-

pleted during the total period of observation<sup>1, 2, 14</sup>. A description of the survival pattern is more likely to provide insight into the nature of the disease and the effect of therapy than the survival rate as of one specified point. Deaths due to all causes were included in the survival statistics. Length of survival was measured from the time of initial biopsy and diagnosis of Hodgkin's Disease to the last follow-up in October of 1973. There were no patients lost to follow-up in the study.

#### STATISTICAL RESULTS

Of the 32 patients with Hodgkin's Disease three were classified as lymphocyte predominance, 17 as nodular sclerosing, nine as mixed cellularity, and three as lymphocyte depletion. The incidence of lymphocyte depletion is higher than in other reported series, but these slides were reviewed extensively by the members of the Pathology Department and are considered proven diagnoses. The mean age of the patients was 38.3 years and the median age was 31.0 years. There were eight patients staged as I-A, one as I-B, six as II-A, four as II-B, one as III-A,

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*Since graduating from Washington University Medical School in 1958, Theodore J. Brickner, Jr., MD, has been certified by the American Board of Radiology. He is a member of the American Society of Therapeutic Radiologists, the American Radium Society and the Radiological Society of North America. He is President of the Northeast Oklahoma Radiologic Society.*

*In 1970, David S. Gooden, PhD, was graduated from the University of Missouri. His specialty is radiological physics. He is a member of the American Association of Physicists in Medicine, the Nuclear Medicine Society and the American Nuclear Society.*



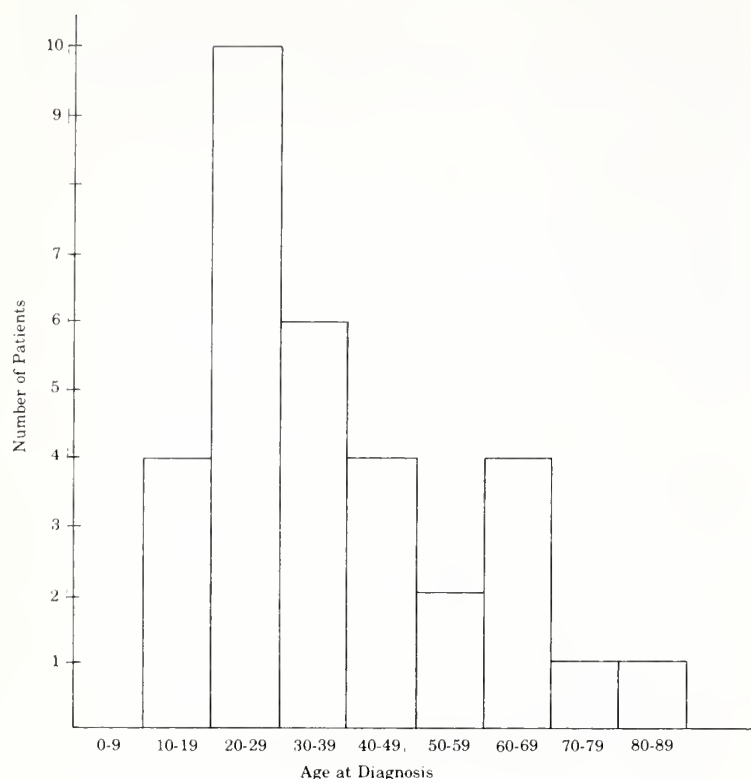


Figure 1. Histogram: Age at Diagnosis of Hodgkin's Disease.

two as III-B, one as IV-A, and nine as IV-B. Twenty-one of 22 Stage I, II, and III patients had lymphograms. Ten of the entire group of 32 patients had laparotomies.

The age distribution of the patients was bimodal showing a peak in the 15 to 40 year age range and another peak in the 60 to 70 year age range (Figure 1). Table 1 refers to initial site of involvement by histological type of initial biopsy and Table 2 shows the distribution of

Table 1  
Initial Site of Involvement  
By Histologic Type of Initial Biopsies

Histologic Type	Involvement			Total
	Above Diaphragm	Below Diaphragm	Above & Below Diaphragm	
Lymphocyte Predominant	3	0	0	3
Nodular Sclerosis	10	2	6	18
Mixed Cellular	4	0	4	8
Lymphocyte Deplete	0	1	2	3
Total	17	3	12	32

Table 2  
Distribution of Histologic Types  
According to Stage and Systemic Symptoms

Histopathologic Type (Rye)	Stage (Rye)				Systemic Symptoms			
	I and II No.	I and II %	III and IV No.	III and IV %	Absent (A) No.	Absent (A) %	Present (B) No.	Present (B) %
Lymphocyte Predominant	3	100	0	0	3	100	0	0
Nodular Sclerosis	11	61	7	39	9	50	9	50
Mixed Cellular	4	50	4	50	4	50	4	50
Lymphocyte Deplete	1	33	2	67	0	0	3	100

histologic types according to stage and systemic symptoms. Figure 2 shows age at diagnosis and histological type of Hodgkin's Disease.

The overall actuarial five-year survival was 49.9 percent (Figure 3). The actuarial five-year survival for Stages I, II and III combined was 54.8% (Figure 4). The actuarial five-year survival for the patients without constitutional symptoms (16 Stage A's) was 36.6% and the actuarial five-year survival for patients with constitutional symptoms (16 Stage B's) was 57.7% (Figure 5). The actuarial five-year survival for Stage A patients, 36.6%, is somewhat misleading since there was such a small number of evaluations during the four to five-year period. The four-year actuarial survival of 60.9% is probably more meaningful and corresponds better with other published reports showing a greater survival for Stage A patients than for Stage B.

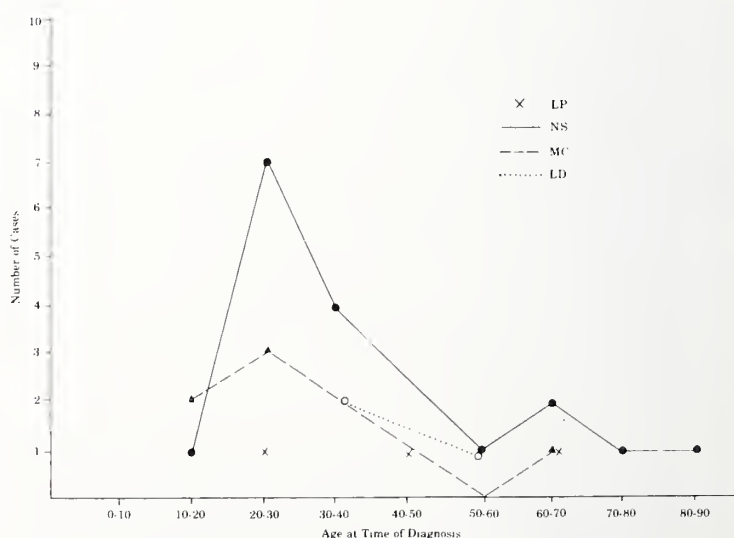


Figure 2. Age at Diagnosis and Histopathological Type of Hodgkin's Disease.

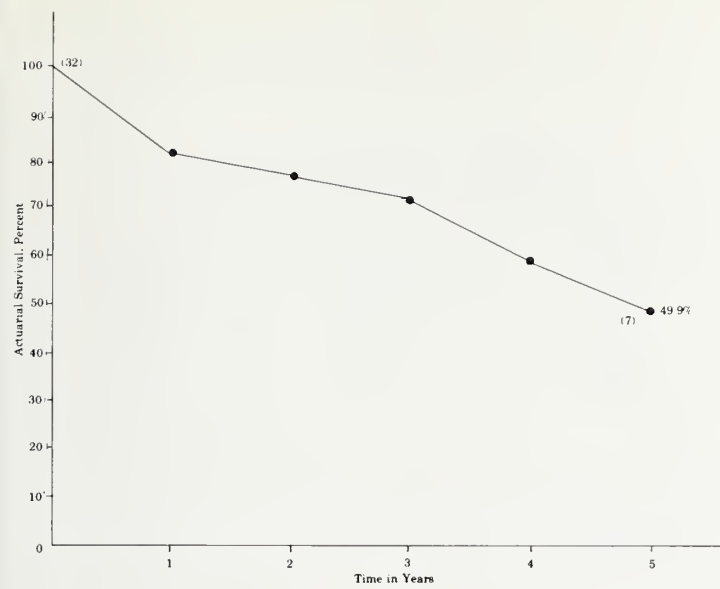


Figure 3. Actuarial Survival of all Cases of Hodgkin's Disease.

Actuarial five-year survivals for Stages I, II, III and IV (Figure 6) and actuarial five-year survival by histological type (Table 4) are included to show trends only since the numbers in each separate group are too small for statistical significance.

### DISCUSSION

A comparison of Saint Francis Hospital five-year statistics was made with other published series (Table 3). Since the number of patients in our group was small, significant comparison

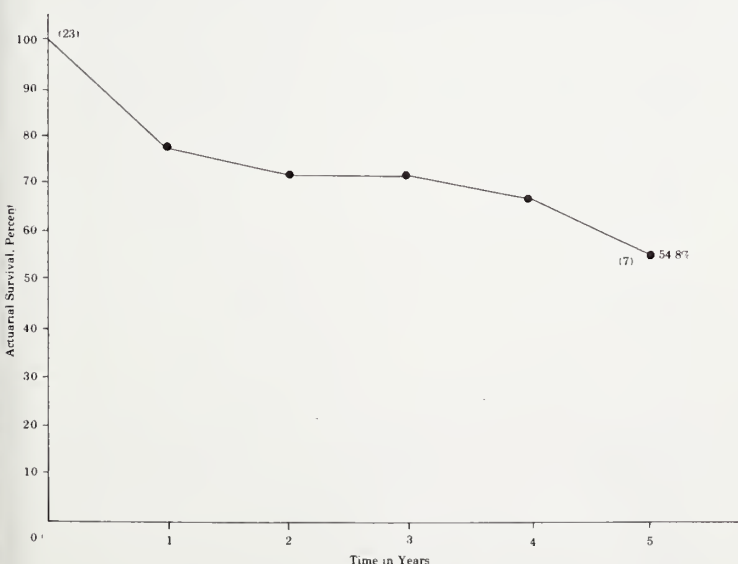


Figure 4. Actuarial Survival for Hodgkin's Disease Cases Stages I, II and III.

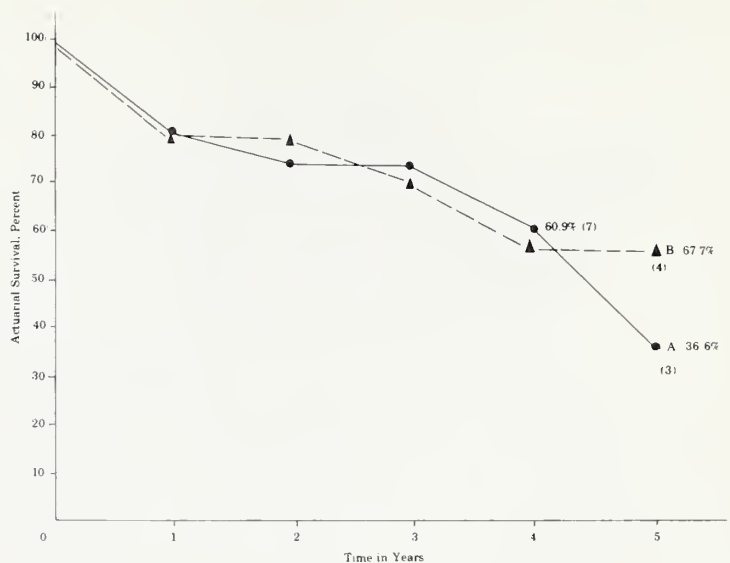


Figure 5. Actuarial Survival for Hodgkin's Disease Cases Stages I, II, III and IV-A Patients Stages I, II, III and IV-B Patients.

with other published statistics is difficult. However, Saint Francis Hospital's overall five-year survival statistics (32 patients) compare favorably with the majority of other reported studies.

The histological type distribution, the distribution of histological type according to stage and systemic symptoms, the age of presentation, and the survival statistics associated with the histologic type are similar to those reported in the literature.

With the opening of The Natalie Warren Bryant Cancer Center at Saint Francis Hospital in the near future, the equipment available for therapy will become much more sophisticated. We are moving toward standardization of

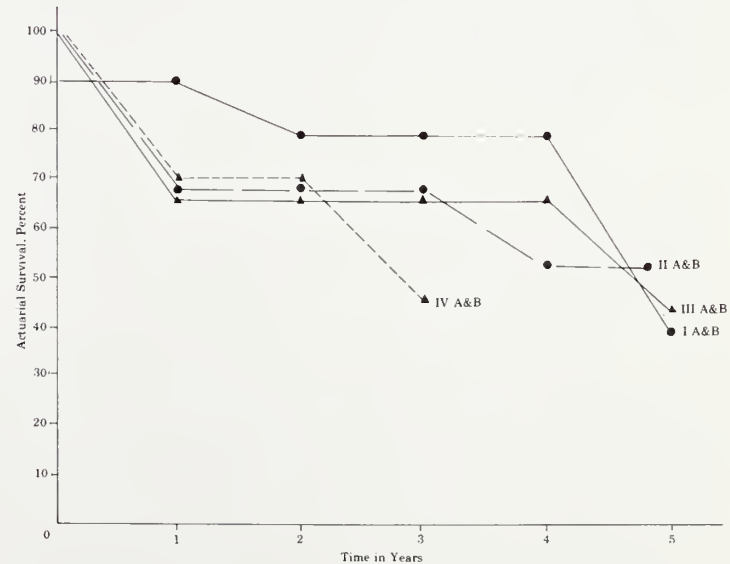


Figure 6. Actuarial Survival for Hodgkin's Disease Cases Stages I, II, III and IV A&B.



Table 3  
Comparison of Actuarial Five-Year Survival  
In The Saint Francis Hospital Study  
With Five-Year Survivals Observed By  
Kaplan, et al<sup>6</sup>, Lukes, et al<sup>9</sup>,  
Franssila, et al<sup>3</sup>, Keller, et al<sup>7</sup>,  
And Patchefsky, et al<sup>12</sup>

	All Stages H.D. 5-Year Survival — %	
SFH Series	49.9%	(1973)
Kaplan, et al <sup>6</sup>	78.0%	(1969)
Lukes, et al <sup>9</sup>	40.0%	(1966)
Franssila, et al <sup>2</sup>	28.0%	(1967)
Keller, et al <sup>7</sup>	57.0%	(1968)
Patchefsky, et al <sup>12</sup>	40.0%	(1973)

diagnostic evaluation and treatment of Hodgkin's patients. In the future, all patients will be managed by an inter-disciplinary group of internists, chemotherapists, surgeons, and radiation oncologists. It will be interesting to compare statistics five years hence to determine if there is the anticipated improvement in survival and lessening of patient morbidity.

We have attempted to demonstrate that collection and evaluation of treatment results is possible with reasonable effort in a general hospital. Although we realize our results are open to criticism because of the small numbers involved, it is encouraging to find that our survival statistics are comparable to other published data<sup>3, 7, 9, 12</sup> with the exception of Kaplan, et al<sup>6</sup>. We hope to improve our results with more sophisticated equipment and refined techniques. If evaluation of our statistics of treatment of other diseases shows a significant deviation from published figures, it will be of real benefit to future patients and will have been well worth the time and effort.

Table 4  
Survival vs. Histopathological Type  
In Hodgkin's Disease

Saint Francis Hospital  
(1973-Actuarial Survival Table %)

Reference	5-Year Survival—%	No. of Cases
LP	100	3
NS	32	18
MC	87.5	8
LD	0	3

#### ACKNOWLEDGEMENT

The authors wish to thank Doctor William P. Illig, Doctor Robert Kotas and Doctor Jane Self for their assistance in this investigation. Special appreciation is also given to Mrs. Marcia Baker and Mrs. Margaret Miller for helping in the preparation of the manuscript. □

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## Oklahoma Drug Laws

ED KELSAY

*Drug laws of importance to the physicians of Oklahoma were changed in 1971 by the enactment of new statutes at both the federal and state levels. Such changes are outlined.*

In October, 1970 the President signed into law the "Comprehensive Drug Abuse Prevention and Control Act of 1970" to become effective on May 1st, 1971. The purpose of the federal law was to collect, codify, and amend more than fifty pieces of legislation enacted by the United States Congress since 1914 relating to the control and diversion of drugs. The act directed that enforcement functions were to be carried out by the Bureau of Narcotics and Dangerous Drugs of the Department of Justice. It also moved narcotic registration of physicians from the Internal Revenue Service to the new bureau.

Last year Congress moved to further consolidate the national drug law enforcement by abolishing the Bureau of Narcotics and Dangerous Drugs and transferring all of that Bureau's functions, including the registration and regulatory responsibilities, to the Drug Enforcement Administration, known as DEA. DEA consolidates into a single command in the Justice Department the drug enforcement resources and functions of the Bureau of Narcotics

and Dangerous Drugs, the office of Drug Abuse Law Enforcement, the office of National Narcotics Intelligence, and the drug investigation and intelligence activities formerly performed by the Bureau of Customs.

In response to the 1970 federal law, the Oklahoma Legislature enacted the "Uniform Controlled Dangerous Substance Act" to become effective on September 1st, 1971. This model state law was designed to mesh with the federal law for maximum compatibility.

Oklahoma's law creates a Commissioner of Narcotics and Dangerous Drug Control as a part of the State Attorney General's Office. The Commissioner is given extensive authority to enforce the state's drug laws and to work with federal and other state agencies.

The primary purpose of both the federal and state laws is to control the traffic in narcotics and dangerous substances and to suppress the abuse of such substances.

Both the state and federal law provide five schedules, or five classifications, of so-called dangerous substances. At the present time the drugs listed in the five schedules at both the state and federal level are basically the same. However, there is a possibility that at some time in the future the drugs listed as dangerous substances in Oklahoma could be considerably different from those listed in that manner by the federal agency. The state will tend to be more inclusive in its list.

The federal law specifies that the U.S. Attorney General may classify drugs as "dangerous



substances" and determine in which of the five schedules they should be listed. Oklahoma's law allows the State Board of Pharmacy to so classify products.

The following is a brief explanation of each of the five schedules. Definitions as found in the state and federal laws are basically the same.

**Schedule I:** Drugs or other substances listed in this schedule are those that have an extremely high potential for abuse. In addition, they have no currently accepted medical use in treatment in the United States.

The federal law gives an additional criterion for listing drugs under Schedule I: "There is a lack of accepted safety for use of the drug or other substance under medical supervision."

Schedule I consists primarily of a listing of the exotic opiates and opium derivatives. However, the hallucinogenic substances are included in this schedule. These include such items as marijuana, psilocybin and LSD.

There is one interesting difference between Schedule I as found in the federal and state law. In the federal law the substance known as peyote is listed under Schedule I, but there is a special exemption in the regulations which states that it may be used in bona fide religious ceremonies of the Native American Church and "Members of the Native American Church so using peyote are exempt from registration." The Oklahoma law does not list peyote at all in Schedule I, but does list mescaline which is a derivative of the peyote plant.

**Schedule II:** Substances in this schedule are described as those which have a "high potential for abuse" and have a "currently accepted medical use in the United States, or currently ac-

cepted medical use with severe restrictions." The state law goes on to say, "The abuse of the substance (listed in this schedule) may lead to severe psychic or physical dependence."

Drugs in this schedule include those formerly known as "Class A Narcotics." When the schedule was originally published, there was only one non-narcotic listed, liquid injectible methamphetamine. Now, due to recent amendments to the schedule, amphetamines and methamphetamines in all forms have been placed here. At the same time phenmetrazine and methylphenidate were moved to this schedule.

On November 5, 1973, the drug methaqualone was added to Schedule II. This hypnotic-sedative is manufactured under a number of trade names, including Quaalude, (Rorer), Sopor (Anar-Stone), Optimil (Wallace), Parest (Parke-Davis), and Somnafac (Cooper).

The most recent additions to Schedule II are amobarbital, secobarbital, and pentobarbital. These were moved from Schedule III in early 1974. It is now anticipated that all barbiturates will be moved to Schedule II in the near future.

**Schedule III:** In this schedule the drugs and substances listed have a potential for abuse that is somewhat less than those items found in Schedules I and II. However, abuse of these drugs may lead to "moderate or low physical dependence or high psychological dependence."

The depressants are listed in this schedule. Both the state and federal law contain the blanket statement that the schedule also includes, "any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid." This is modified, of course, by the recent movement of Schedule III items to Schedule II, as noted above.

This schedule also contains some of those drugs formerly known as "Class B Narcotics." Paregoric, formerly known as an "exempt narcotic," is also in Schedule III.

**Schedule IV:** While the abuse potential for items in Schedule IV is very low, it may lead to "limited physical dependence or psychological dependence relative to the substances listed in Schedule III." Most of the tranquilizers are found in this schedule.

**Schedule V:** Drugs in this schedule include those preparations formerly known as "exempt narcotics," such as the cough syrups containing codeine. These items have a very low potential for abuse, but could cause "limited physical

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dependence or psychological dependence . . .”

In 1971 all practitioners were required to replace their old IRS narcotic numbers with a Bureau of Narcotics and Dangerous Drug registration number. This number has now been changed to the Drug Enforcement Administration registration number. The state law also requires registration of physicians and the payment of a \$5.00 fee.

In the event that a physician maintains more than one office or principal place of professional practice where controlled substances are either dispensed or administered, it is necessary for him to have a separate DEA registration number for each such place. It is not necessary for him to have a separate DEA number for a hospital, since the hospital has its own, or a separate number for an office where he will neither dispense nor administer drugs.

The state law requires only one state registration number, even if a physician does maintain more than one office.

The terms administer, dispense, and prescribe are used extensively throughout both the federal and state law. To prescribe simply means to issue a prescription for a patient. However, the term “administer” means the “. . . direct application of a controlled dangerous substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient . . .”

The term “dispense” means the giving of drugs in some type of bottle, box or other container to the patient.

Both the federal and state laws require annual renewal of controlled dangerous substance registrations. On or about the first day of October the State Commissioner of Narcotics and Dangerous Drug Control sends a renewal application to all physicians in the state holding a current state registration. The renewal application is to be signed and returned to the state office with a \$5.00 registration fee. The actual renewal date is November 1st each year.

While the state renews all registration numbers at the same time each year, the sheer number of physicians in the United States makes a single renewal date an impossibility for the federal number. Federal re-registration dates are staggered so that approximately 1/12th of the total registrants will come up for renewal during any given month. Approximately one month prior to a registrant's expiration date, he will receive an application for renewal for each of his DEA numbers. A check or

money order in the amount of \$5.00 per number must accompany the renewal form when returned.

Any physician who has not received a registration form or who becomes eligible for registration should contact the registration branch of the Drug Enforcement Administration, PO Box 28083, Central Station, Washington, DC 20005. At the same time they should also contact the Oklahoma Commissioner of Narcotics and Dangerous Drugs Control at 820 NE 63rd Street, Oklahoma City, Oklahoma 73105, and ask for a registration form.

The Drug Enforcement Administration and the state registration agency exchange information and since the two laws are mutually inclusive, a physician who registers with only one or the other will not be in compliance with either law and cannot legally prescribe, administer, or dispense any controlled dangerous substance.

Any prescription for a controlled substance must bear the full name and address of the patient, the full name, address and DEA registration number of the practitioner. It is not necessary for him to list his state registration number on a prescription.

The law places the responsibility for properly preparing a prescription on the prescribing physician. At the same time, however, the pharmacist has a responsibility not to fill an improperly prepared prescription. Thus any physician who fails to include all of the required information is not only violating the law, he is also placing the pharmacist in an awkward position of also either violating the law or refusing to fill the prescription.

The law specifies that items in Schedule I may not be prescribed, and that it is unlawful for anyone to prescribe controlled substances for the purpose of maintaining an individual's dependence on some drug. There are very strict exceptions to the latter prohibition in authorized methadone maintenance programs.

The prescription itself may be prepared by a secretary or nurse, but the signature must be that of the practitioner and must be manually signed in either ink or indelible pencil.

Prescriptions for Schedule II items, including amphetamines, may be filled by a pharmacist only pursuant to a written prescription. However, in an emergency situation both the state and federal laws provide that a pharmacist may dispense these items upon receiving an oral authorization. The amount prescribed in this



manner must be limited to that amount which would be adequate to treat the patient during the emergency period only.

Certain requirements must be met in the "emergency prescription" situation. The pharmacist is required to reduce an oral prescription to writing, containing all of the information that is required on a standard written prescription. In addition, he must make every effort to properly identify the physician.

Within 72 hours after the emergency oral prescription is given, the prescribing physician must cause a written prescription for the emergency quantity to be delivered to the dispensing pharmacist. This prescription must have written on its face, "authorization for emergency dispensing," and the date that the oral order was given. If this prescription is not delivered to the pharmacist within 72 hours, the pharmacist must notify the Drug Enforcement Administration of failure to deliver.

The refilling of any prescription for a controlled substance listed in Schedule II is specifically prohibited by both federal and state law.

Prescribing of substances listed in Schedules III and IV is a little less stringent. A pharmacist may dispense these items only pursuant to a written prescription signed by the physician or an oral prescription made by a physician and reduced to writing by the pharmacist. Here again, the prescription must contain the full name and address of the patient, the full name, address, and DEA registration number of the physician.

No prescription for a controlled substance as listed in either Schedule III or IV can be filled or refilled more than six months after the date on which it was originally issued and no such prescription can be refilled more than five times during the six month period. Each time it is refilled this will be noted on the back of the prescription, or in some appropriate and uniformly maintained records. The notation shall be initialed and dated by the pharmacist and will state the amount dispensed.

After the six month date, or the fifth refilling, additional quantities of any substance listed in Schedules III and IV can be dispensed only upon receiving a new prescription, either oral or written, from the physician.

No prescription for a Schedule III or IV sub-

stance which is a narcotic drug may be refilled.

The state law in regard to prescribing Schedule V items simply says, "No controlled dangerous substance included in Schedule V may be distributed or dispensed other than for a legitimate medical or scientific purpose."

Paregoric has a special statute in Oklahoma which states that it "May not be dispensed without a written or oral prescription. The refilling of a prescription for paregoric shall be unlawful unless permission is granted by the prescriber, either written or oral."

If a physician wishes to allow a patient to refill a paregoric prescription, he should simply note on the prescription that it is "refillable upon request." Otherwise, it will be necessary for the pharmacist to contact him each time a refill request is made. Even with the refillable notation on the prescription, any prescription for paregoric is still subject to all of the requirements for Schedule III items, *ie*, it cannot be filled more than five times and cannot be refilled longer than six months after the date of the original prescription.

Whenever a pharmacist fills a prescription for a controlled substance he is required to affix to the container or package a label showing the pharmacy name and address, serial or prescription number, date dispensed, the patient's name, name of the physician, and the directions for use and any cautionary statements that are contained in the prescription or are required by law.

In the event that a physician dispenses any controlled dangerous substance, the state law requires that he shall affix a label showing the date dispensed, the name of the patient, the physician's name, address, and his state registration number. This is the only time when a physician is required to use the state number.

Labeling is not required whenever a physician distributes samples of any controlled dangerous substance in the manufacturer's package free of charge. However, if he repackages or charges for the substance, he must meet the labeling requirements.

Regarding samples, the state law says, "No person shall distribute samples of controlled dangerous substances to a practitioner without simultaneously preparing and leaving with that practitioner a specific, written list of the items so distributed, the form and control of which shall be prescribed by rules promulgated by the Commissioner."

Record keeping requirements under the fed-



eral and state laws are similar to those for the old Class A narcotics.

Physicians are not required to keep records on items prescribed. Also, no record is necessary on non-narcotic controlled items which a physician dispenses, so long as he makes no charge for such dispensing either separately or together with charges for other professional services. This covers the situation where a physician only distributes professional samples and does not actually sell the drug either directly by making an actual charge for it, or indirectly by increasing some professional fee.

Every two years a physician must inventory all dangerous controlled substances that he has in stock. This includes listing complimentary or physician's samples, also. The inventory must be maintained in a written, typewritten, or printed form. It must be taken every two years within four days of the biennial inventory date. It can be taken either at the opening or the closing of business on that date, but this must be noted on the inventory.

For most physicians, May 1st is the inventory date. When first enacted the federal law required that all physicians inventory their stocks on May 1st, 1971. Any physician who registered after that date will have a different inventory date. While it is necessary that the physician retain the inventory for two years, he is not required to report it to anyone. But, the inventory must be available for inspection by appropriate authorities.

It is not necessary to maintain a perpetual inventory. However, it has been suggested that such a perpetual or running inventory would probably be the easiest way to meet the federal record keeping requirements.

The state law requires that a physician shall maintain his records and inventory in conformance with the requirements of the federal law.

As to the records necessary, a separate record must be maintained on those Schedule II items which a physician either administers or dispenses. This is basically the same requirement as was made on the old Class A narcotics.

Record keeping on Schedule III through V items is not nearly as stringent. Regulations simply specify that the physician's record on these items must be kept in such a manner as to be easily retrievable.

While some physicians are relying on a notation on the patient's record as fulfilling the retrievability portion of the law, as a practical matter the running inventory approach would

be best. Thus a practitioner could simply note on an inventory chart that 25 tablets of some items were dispensed to patient X on a certain date.

Federal regulations require that all dangerous controlled substances stored by a physician should be kept in a "securely locked, substantially constructed cabinet." The regulations specify, however, that a pharmacy may dispense Schedule III, IV, and V substances throughout a stock of non-controlled substances "in such a manner as to obstruct the theft or diversion of the controlled substances."

In the event there is a theft or a "significant loss" of controlled substances, the physician must notify the regional office of the Bureau of Narcotics as soon as it is discovered.

Oklahoma's law contains a number of penalties that may be of specific importance to physicians. As an example, the theft or burglary of any controlled substance is punishable by imprisonment up to ten years.

It is declared a felony, with imprisonment up to ten years, to obtain or to attempt to obtain any controlled substance by fraud, deceit, misrepresentation, subterfuge, by the forgery or alteration of a prescription or written order, by the concealment of a material fact, or by use of a false name and address. Information communicated to a physician in an attempt to unlawfully obtain controlled substances is not privileged.

Provision is made for the fine or imprisonment of a person who refuses or fails to keep proper records and otherwise to comply with the record keeping provisions of the law, or who refuses to allow an authorized inspector to inspect such records and the premises where controlled substances are kept. Anyone violating this particular section may find themselves fined up to \$1000. In the event it can be proved that a person knowingly and intentionally has violated this section of the law, the punishment can be up to five years imprisonment and a fine up to \$10,000.

New penalties to help control drug abuse or misuse were established by the 1971 act. In some instances these new penalties change the old laws of the state.

Any person who knowingly or intentionally possesses a controlled dangerous substance, unless it was obtained in a legal manner, may be found guilty of illegal possession. Conviction for illegal possession of a drug in Schedules I or II, except marijuana, is punishable by imprisonment for not less than two years nor more than



## *Drug Laws / KELSAY*

ten years. A second or subsequent violation will draw from four to twenty years imprisonment.

Illegal possession of items listed in Schedules III, IV, and V, and marijuana, is now a misdemeanor punishable by confinement for not more than one year. A second or subsequent conviction is a felony punishable by two to ten years imprisonment. Previously the illegal possession of marijuana had been a felony.

To manufacture, distribute or dispense any narcotic drug or lysergic acid diethylamide (LSD) is punishable by imprisonment from five to twenty years in the state penitentiary and a fine up to \$20,000. The statute states that such a sentence shall not be "subject to statutory provisions for suspended sentences, deferred sentences, or probation."

The manufacturing, distribution, or dispensing of any controlled substance listed in Schedule I through IV, other than the narcotics and LSD, is punishable by imprisonment from two to ten years and a fine of not more than \$5,000. Here again, statutory provisions for suspended or deferred sentence and probation are declared inoperable.

The manufacturing, selling, or giving away of items listed in Schedule V is punishable by imprisonment of up to five years and a fine of not more than \$1,000.

Any person convicted of a second or subsequent violation of the statute prohibiting manufacture, distributing or dispensing of a controlled substance may be punished by a term of imprisonment twice that otherwise authorized and by twice the fine authorized for a first conviction.

One special provision of the law dealing with offenses and penalties provides that anytime a

person who is at least 21 years of age gives or sells to a person under 18 years of age a controlled substance he may be punished by twice the fine and twice the imprisonment that is otherwise authorized. As an example, if someone over 21 provides someone under 18 with LSD, and is convicted, they could find themselves imprisoned for a minimum of ten years up to a maximum of forty years with a possible fine up to \$40,000.

While the penalties may sound harsh, the Oklahoma law does provide that first time offenders may plead guilty, or be found guilty of possession of a controlled dangerous substance and the court may, by not entering a judgment of guilt and with the consent of the person, defer any further proceedings and place the person on probation. The court is allowed to impose reasonable terms and conditions on such probation and may require the individual to submit to treatment or rehabilitation.

If such a probation is violated, the court may then enter an adjudication of guilt and proceed to levy the punishment provided by the statutes. If a person completes his probation honorably, this portion of his life may be expunged from the records.

The state law provides, "An expunged arrest or conviction shall not thereafter be regarded as an arrest or conviction for purposes of employment, civil rights, or any statute, regulation, license, questionnaire, or any other public or private purpose . . ."

The intermeshing of federal and state laws should lead to a more uniform approach to the control of those drugs and substances declared to be dangerous and to have an abuse potential. While it is not a solution to the national problem of drug abuse, the combination of national and state laws is already helping to stem the availability of abusable drugs. □

# The Development of American Medical Research and the Influence of John D. Rockefeller

## PART II

WILLIAM O. SMITH, JR.  
With The Special Help of  
ERMA McKEE

*Two men with vision, John D. Rockefeller and Doctor William H. Welch, recognized the unique opportunity and transformed America's research potential into reality.*

In this country we have come to a period when we can well afford to ask the ablest men to devote more of their time, thought, and money, to the public well-being.<sup>24</sup>

John D. Rockefeller revealed the development of his principles in *Random Reminiscences*, published in 1909. His concept of stewardship and his strong religious convictions were instilled during his childhood. His early philanthropy was directed toward the Church and religious activities. Eventually his gifts could no longer keep pace with the increase in his wealth and he adopted a broader philosophy and covered a wider social spectrum in the bestowal of his money. Increased sophistication in giving necessitated a more intricate definition of philanthropy:

The best philanthropy, the help that does the most good and the least harm, the help that nourishes civilization at its very root, that most

widely disseminates health, righteousness and happiness, is not what is usually called charity. It is, in my judgment, the investment of effort or time, or money, carefully considered with relation to the power of employing people at a remunerative wage, to expand and develop the resources at hand, and to give opportunity for progress, and healthful labour where it did not exist before.<sup>24</sup> (pp 141-142)

Rockefeller pointed out that the philanthropist is hampered by the necessity to give careful consideration to the effectiveness of proposed projects. He should not apply his money simply to remedy misfortune. Deliberate reasoning points to the benefit of assisting projects like the scientific investigation of disease, when emotion would prompt direct aid to the ill. Help should be afforded the "heroic men and women who are devoting themselves to practical and essential scientific tasks." Rockefeller noted the spirit of heroism in the men who sacrificed their lives to conquer yellow fever. Though he gave generously to causes he considered worthy, and had a keen interest in their success, he made it a policy never to interfere in the pursuit of the goals.<sup>24</sup> (pp 147-149)

Another of Rockefeller's vital characteristics was a strong emphasis on organizing his philanthropic activity in the same way as his business efforts. He extended this concept to its extreme in his proposition for the establishment of combinations or "trusts" in charitable enterprise. The consent of Andrew Carnegie to be on the Rockefeller Foundation General Edu-



cation Board he considered a step in this direction, and he praised Carnegie's enthusiasm for philanthropy.

The creation and development of the Rockefeller philanthropic organization is attributed to the triumvir — John D. Rockefeller, John D. Rockefeller, Jr., and Frederick T. Gates. Each played a different role. Gates and Rockefeller Jr. shared in the exploration for new ideas, and the latter acted as liaison to his father, who passed final judgment on the more important matters. The relationship between the three men was one of close cooperation and complete frankness.

John F. Gates had conceived the idea of establishing an institute for medical research with the Rockefeller wealth. This idea gained the support of an important ally, John D. Rockefeller, Jr. He and Gates solicited the opinions of educational and medical leaders and analyzed the suggestions through the years 1898-1900. Rockefeller, Jr. resolved to expand his knowledge of medical research, and accordingly, he consulted L. Emmett Holt, MD, a respected pediatrician. In November 1900 the two men conversed for several hours, as Holt recalled:

At that time the results of the application of diphtheria anti-toxin were new and most impressive . . . The point made was that diphtheria antitoxin was not a chance discovery but the result of patient and laborious laboratory work in which fundamental biological principles had been applied. The suggestion presented was that what was needed to solve many of the other great problems in medicine were men and resources which could be devoted solely to the work of research.<sup>1</sup> (p 112)

John D., Jr. was impressed by Doctor Holt and consulted him frequently. He asked Holt to participate in the organizing committee of the institute.

The senior Rockefeller's three-year-old grandson died of scarlet fever in December 1900. This strongly affected Rockefeller, particularly when the attending physicians informed him that the cause and effective treatment of scarlet fever were unknown. This event may have been the catalyst at this point in time for the transformation of the proposal from the stage of consideration to active planning. Rockefeller Jr. then arranged a dinner meeting with Doctors Holt and Christian Herter. Holt was a leading practitioner and Herter was principally a scientific investigator. John D. Jr. asked them

to share their differing viewpoints in the selection of talented men to direct the evolution of the institute. The name of William H. Welch headed their list, which also included Herman M. Biggs, New York City Health Officer, T. Mitchell Prudden, a New York pathologist, and Theobald Smith of Harvard. These men, together with Holt, Herter, and Simon Flexner, Professor of Pathology at the University of Pennsylvania, accepted appointment to the board of the proposed institute.

While each was a distinguished man, one predominated from this point through the first years of the institute. This is not surprising, because William H. Welch, widely known as "Popsy," was the most prominent leader in the entire field of North American medicine. Having been a recipient of the German training emphasizing creative investigation, he became perhaps the most outstanding, and certainly the most influential American disciple of that effort. Though at first he had been depressed about the inability of this country to nurture the scientific talent of its young men returning from Europe, he eventually gained an optimistic perspective. Now he could bend his every effort to awaken America's potential for contributing to medical knowledge.

Following the initial meeting in March 1901 between Rockefeller, Holt, and Herter, the latter informed Welch of the concept of the institute and solicited his active participation. Herter emphasized the cautious approach to the venture. Welch, perhaps better than anyone, realized that caution was needed because he was not certain that this country was prepared to accept and support an independent institute solely devoted to research. Herter also assured Welch that Rockefeller's motivation was humanitarian and that the desire for practical results would not hamper scientific efforts. He expressed the wish of his associates to name Welch as chairman. Welch replied that he considered Rockefeller's undertaking of utmost importance to humanity. He accepted a position on the board but declined the chairmanship. At

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this point he was disturbed that the institute had no university affiliation, since he believed that the stimulus of educational responsibilities was a prerequisite for productive scientific investigation. He later tried to establish a connection between the institute and Columbia University but the Rockefellers firmly opposed this suggestion. Welch found himself in the ironic position of molding an institution along concepts differing from the university tradition of which he remained an ardent proponent.<sup>25</sup>

At the meeting in May 1901 of the American Association of Physicians, Welch met with the institute organizers. Rockefeller had previously announced his intention to give twenty thousand dollars a year for ten years in support of the institute. The advisory group now felt the confidence to solidify their plans. They invited Theobald Smith to be the director. Smith refused the directorship on the grounds that his personal research interests might confine too narrowly the work of the institute.

The Rockefeller Institute for Medical Research was legally incorporated in June 1901, and the editorials in the New York newspapers noted its significance for the future of American medicine.<sup>26</sup> The board, however, decided to postpone the opening of the laboratory and concentrate for the interval on meticulous apportionment of the funds as research project grants. Rockefeller Jr. had extracted from Welch his consent to become president of the board. Because there was no director between 1900 and 1902, Welch assumed the distribution of more than twenty-six thousand dollars to research projects at many universities. Welch's acceptance of this arduous task was fortunate. His intense desire for scientific information and his position as editor of the *Journal of Experimental Medicine*, made him uniquely aware of the research under way throughout the nation. Grants were made only to Americans, but many chose to work in established European research institutes. As Simon Flexner pointed out, the fact that these funds, though quite small by modern standards, were avidly sought by investigators is indicative of the limited quantity of resources then available.<sup>4(p 276)</sup>

Welch felt that the time for establishing the laboratory depended on securing an excellent director and staff. Gates was by now somewhat impatient for the implementation of his plans, and Welch had become optimistic in view of the success of the grants-in-aid program. At the

board meeting on January 11, 1902, Welch nominated Simon Flexner for the directorship, and the members strongly approved this choice. Flexner accepted the position and in April submitted a scholarly prospectus covering the scope and philosophy of the Institute and details of its organization and operation. He did not delineate the areas of research but felt that "the scope of the institute should be broad enough, when fully organized, to cover the entire field of medical research in respect to both man and animals. . . ." <sup>2(p50)</sup> He emphasized that large endowments would be needed to secure the most qualified men. Flexner's concept of the necessary facilities provided a working basis for the board. Together with the estimated costs for the initial construction and the future funding of three laboratory departments and a hospital, the board presented this proposal to the Rockefellers.

Rockefeller, Jr. informed his father of the board's program which would require five million dollars. Immediate building and equipment costs were estimated at approximately four hundred thousand dollars, and annual operating expenses at nearly sixty thousand dollars. An acceleration of efforts was now expedient because a rival research facility, the Carnegie Institute, had been established, and others were planned. The elder Rockefeller agreed to make an initial gift of one million dollars, but deferred approval of the proposed total funding. At the June meeting the board began sketching the details and initiated a search for land. An appropriate site was located, and the purchase completed in the following year.

An important step in the maturation of the Institute was the acquisition of the *Journal of Experimental Medicine* late in 1902. This had previously been compiled and published at Johns Hopkins under the editorship of Welch. For fifteen years Flexner served as chief editor of the *Journal* which was devoted principally to the work of the Institute, and soon became one of the most respected research publications in the world.

Though the European institutes typically revolved around the interests of a single scientist, Flexner resolved to impose only a minimal structure. He took to heart the advice given in Naples by the distinguished researcher Anton Dohrn that the staff be allowed a large measure of independence in the choice of projects and methodology.<sup>2(p 58)</sup> The hallmark of the Rockefel-



ler Institute was to be freedom. However, there remained an atmosphere of close cooperation.

The permanent home of the Institute was ready for occupancy in April, 1906. The formal dedication on May 11 included speeches by Holt, Welch, President Butler of Columbia University, and President Eliot of Harvard. Doctor Holt recounted the history and philosophy of the Institute:

While the purpose of the Institute will be research, not instruction, it can not fail to exert a considerable influence in medical education, since many of those who will receive their training within its walls will, doubtless, go elsewhere to assume positions of responsibility in teaching institutions.

Holt also emphasized the need for adding hospital facilities, so that the workers in the laboratory would appreciate the relation of their results to the problems of practical medicine. He perceptively observed that while European institutions aided greatly as models, America needed a substantially different type of institution. Although the institute would require many years to achieve full development, Holt stressed the value of a general policy at the outset. The cornerstone of the development rested on the founder's intention that the funds be administered "to accomplish the most for humanity and science."<sup>27</sup>

In his speech entitled "The Benefits of the Endowment of Medical Research," Welch eloquently explained the basis for the growing recognition of medical science as a worthy object of endowment and expressed the necessity for continued assistance:

The awakening of this wider public interest in scientific medicine is attributable mainly to the opening of new paths of investigation which had led to a deeper and more helpful insight into the nature and the modes of prevention of a group of diseases — the infectious diseases — which stand in a more definite and intimate relation to social, moral, and physical well-being of mankind than any other class of diseases. . . . Not medicine only but all the forces of society are needed to combat these dangers, and the agencies which furnish the knowledge and the weapons for this warfare are among the most powerful for the improvement of human society.

While the science of medicine would require enormous financial support, Welch affirmed that the benefits of mankind would always be out of all proportion to the money expended.<sup>7</sup> (pp 74-82)

The security of the Institute was assured in November, 1907, when Rockefeller gave a permanent endowment of \$2,620,610. Previously, the board had requisitioned Rockefeller to meet necessary expenses, but now it was essential to set up appropriate financial machinery. All desired to preserve the spirit of trust and cooperation between the Rockefeller donors and the previous board of directors.

A new Board of Trustees was established, and the Board of Directors was retitled the Board of Scientific Directors. The Board of Trustees consisted principally of financiers, but included representatives from the scientific directors. To maintain the atmosphere of scientific freedom, Prudden suggested that the trustees confine their administration to financing of the institution and leave the selection and funding of specific subjects for investigation to a joint committee composed largely of scientists. To this the trustees agreed. The structure allowing such independence was unique in the development of American philanthropy.

As the confidence of the Rockefellers in the Institute continued to grow, so did their support. The success of Flexner's antiserum in controlling the Ohio epidemic of spinal meningitis deeply impressed Rockefeller. In the spring of 1907 he had authorized the establishment of the hospital. The board selected Doctor Rufus Cole from Johns Hopkins to head the clinical facilities, which were inaugurated on October 17, 1910. Simon Flexner described its importance to the work of the Institute:

The primary purpose of the institute may be defined as the attempt to add to knowledge by discovery, and to apply that knowledge to the prevention and alleviation of disease. When findings were made, they were at once rendered generally available; the time soon came when practical applications could be carried out in a hospital added to the laboratories. Thus both pure and applied science were cultivated side by side. It was recognized that the atmosphere which the pursuit of pure science creates is highly favorable to the promotion of applied science . . . .<sup>28</sup>(p 289)

On the day the hospital opened, Rockefeller announced the gift of an additional three million eight hundred thousand dollars to the Institute. Eventually a Department of Animal and Plant Pathology was established and a Department of Laboratories expanded to cover the fields of biophysics and experimental surgery.<sup>29</sup> Further discussion of the development of the



Rockefeller Institute to its full maturation would require a listing of innumerable contributions, and the exposition of its influence on many American men of science. Its structure changed only slightly after 1910, but the Institute continued to gain in importance.

Two major currents of change — one social and economic, and the other scientific — met one another at the beginning of the twentieth century. The gradual synthesis of these forces was culminated by the Rockefeller Institute for Medical Research. Two great men combined their talents and efforts to give it birth. John D. Rockefeller, Sr. developed the financial resources. Doctor William H. Welch brought the influence of the American medical profession to the enterprise. "Only when a permanent institute of research has been established, can medicine be really said to have taken root."<sup>3</sup> (p 267)

Aside from the scientific contributions, the stature of this institution rests on two pillars. First, just as Gates and the Rockefellers envisioned initially, the Rockefeller Institute for Medical Research has served as example and inspiration for establishment of many other research foundations in this country. Among the earliest were the Carnegie Institute in Washington, the McCormick Memorial Institute for Infectious Diseases in Chicago, and the Phipps Institute in Philadelphia. It truly served as the catalyst in the American rise to research leadership. Secondly, the Rockefeller Institute was the product of the union of American social, cultural and economic forces into a tremendously important humanitarian effort. It serves as a prime example of the achievements of this period in American history.

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## AMA ANNUAL CONVENTION JUNE 22-26, 1974 CHICAGO, McCORMICK PLACE

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| 09 <input type="checkbox"/> Internal Medicine                      | 22 <input type="checkbox"/> Urology                              |
| 24 <input type="checkbox"/> Neurological Surgery                   |  |
| 25 <input type="checkbox"/> Neurology                              |  |

### General Registration

\_\_\_\_AMA members and their guests: no fee

\_\_\_\_Non-member physicians: \$25

\_\_\_\_Guests of non-members: \$5

\_\_\_\_Medical students, interns and residents: no fee

My remittance of \$\_\_\_\_\_is enclosed.

(Make check payable to American Medical Association.)

Check must accompany registration.

RECOMMENDATIONS FOR SUPERVISION  
OF TUBERCULOSIS PATIENTS

Tuberculosis patients who complete adequate chemotherapy should be considered *cured* and have no need for routine lifetime periodic recall. Prolonged followup of such patients diverts clinic resources from the crucial tasks of providing services to cases currently on chemotherapy.

Highest priority should be given to prompt and thorough treatment of newly diagnosed cases. Inactive cases diagnosed in previous years who have never had chemotherapy or who have had less than 18 months of two drug chemotherapy should receive preventive treatment.

If a patient has not responded well to drugs or has had an irregular course of treatment, efforts should be made to complete adequate therapy. Special treatment programs, such as directly administered ambulatory therapy, should be considered for such patients. Continuing periodic chest x-rays and bacteriologic exams should be considered only for persons in whom all attempts at therapy have failed. If such per-



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sons are in occupations where infectiousness may have serious consequences (such as some school and hospital personnel) they should be examined more than once a year or, if feasible, transferred to areas where there are minimal consequences to contacts if the person becomes infectious.

Persons who have responded well and completed the recommended course of therapy should be discharged with instructions to return only if they develop symptoms that could be caused by tuberculosis. Persons who have completed preventive therapy should be discharged with similar instructions.

References: Morbidity and Mortality Weekly Report, Volume 23, Number 8, February 23, 1974.

COMMUNICABLE DISEASES IN OKLAHOMA FOR MARCH, 1974

DISEASE	March 1974	March 1973	February 1974	Total To Date	
				1974	1973
Amebiasis	2	—	—	4	3
Brucellosis	2	—	—	2	2
Chickenpox	279	476	91	414	715
Encephalitis, Infectious	3	1	3	9	2
Gonorrhea (Use Form ODH-228)	1032	951	670	2400	2669
Hepatitis, A, B, Unspecified	100	127	128	308	276
Leptospirosis	—	—	—	—	—
Malaria	—	—	1	1	—
Meningococcal Infections	2	2	1	7	4
Meningitis, Aseptic	1	2	7	9	4
Mumps	134	77	51	208	156
Rabies in Animals	13	23	8	29	38
Rheumatic Fever	1	2	—	3	5
Rocky Mountain Spotted Fever	—	—	—	—	—
Rubella	5	13	3	18	40
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	5	11	3	11	15
Salmonellosis	13	18	23	49	42
Shigellosis	4	23	13	29	40
Syphilis, Infectious (Use Form ODH-228)	21	41	11	45	219
Tetanus	—	—	—	—	—
Tuberculosis, New active	27	29	20	65	73
Tularemia	1	2	1	2	6
Typhoid Fever	—	—	—	—	1
Whooping Cough	1	1	3	5	8

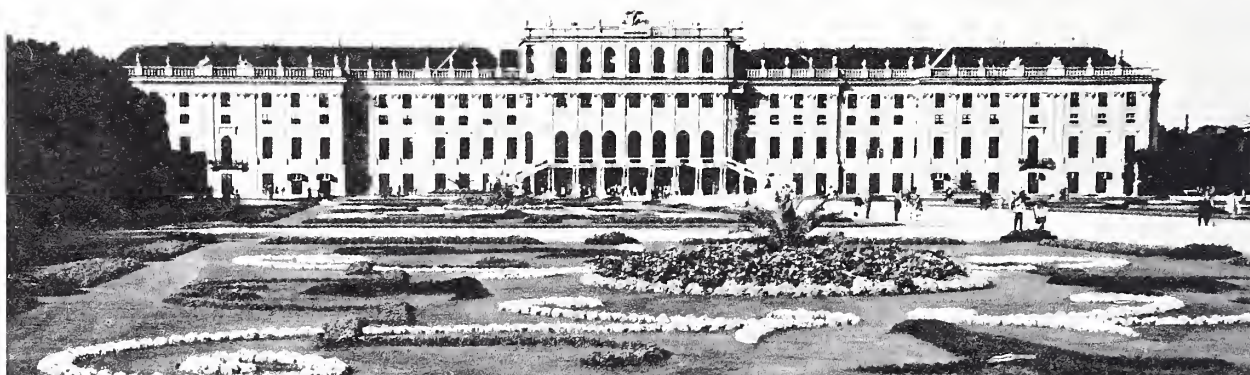
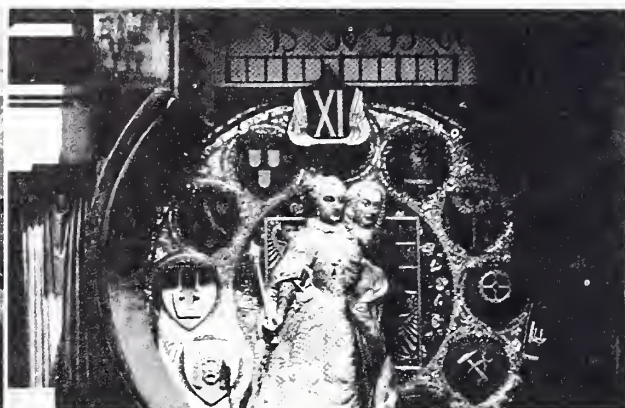
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## House of Delegates Considers PSRO

In a special called meeting, the OSMA House of Delegates considered what action should be taken regarding Professional Standards Review Organizations in Oklahoma. The delegates met in Oklahoma City on Saturday afternoon, April 6th.

Hillard E. Denyer, MD, Chairman of The Oklahoma Foundation for Peer Review submitted the foundation's report regarding PSRO possibilities in Oklahoma to the House for consideration. The report included a special report that the foundation commissioned by the Dikewood Corporation of Albuquerque, New Mexico.

Both the foundation report to the House of Delegates and the Dikewood Corporation report are reproduced in this issue of *The Journal*.

Following extensive debate, the House of Delegates adopted the following motion: "We move that the OSMA House of Delegates delegate to the Board of Trustees the authority to allow the

Oklahoma Foundation for Peer Review to apply for a planning contract after July 1st, 1974, when and if, in the judgment of the Board of Trustees, this should be done, and that the current report of the OFPR be approved and that the OSMA Board of Trustees be authorized to continue diligent work to repeal PSRO."

At the time the House of Delegates met the OSMA had already received indications from seven members of the Oklahoma Congressional Delegation that they favored repeal of the PSRO portion of Public Law 92-603. Those favoring repeal included Senators Henry Bellmon and Dewey Bartlett along with Congressmen James Jones, Clem McSpadden, Tom Steed, John Jarman and Happy Camp.

Two members of the delegation went beyond merely declaring they favored repealing PSRO. Senator Henry Bellmon and Congressman Clem McSpadden both introduced bills into Congress calling for the repeal of PSRO. □

### Report of The OKLAHOMA FOUNDATION FOR PEER REVIEW

Presented At  
Special Session, OSMA House of Delegates  
April 6, 1974

#### I. INTRODUCTION:

This report is for the purpose of informing the House of Delegates as to the investigative work accomplished and in process by the Oklahoma Foundation for Peer Review in its role of assessing the impact of Section 249F of Public Law 92-603 (PSRO) upon the practice of medicine in Oklahoma. A secondary purpose is to seek guidance from the House of Delegates as to a future course of action in dealing with this problem.

#### II. BACKGROUND:

PSRO was first introduced into Congress as an amendment to a Social Security bill in 1969 . . . despite opposition from the OSMA and other elements of organized medicine, it became

law in 1972 and was scheduled to become effective on January 1, 1974.

In anticipation of the passage of some form of peer review law and to perhaps control its implementation through a professional organization, the OSMA House of Delegates created the Oklahoma Foundation for Peer Review as a non-profit corporation in 1971 . . . a Board of Directors was elected . . . but the Foundation was not immediately activated.

At the 1973 annual meeting of the OSMA House of Delegates, a membership survey was authorized in order to establish a sense of direction on the PSRO issue. The survey, as prescribed by the House of Delegates, was carried out in May, 1973. It contained a description of the law and pro and con arguments regarding participation or non-participation (the law pro-



vides that only physicians may apply to operate PSRO during the period of January 1, 1974 to January 1, 1976). The survey reply card asked physicians to answer "yes" or "no" to the following question:

"The Oklahoma Foundation for Peer Review should be activated to undertake preliminary investigation of the PSRO law and the forthcoming regulations, with the final decision to apply for PSRO involvement remaining vested with the OSMA House of Delegates."

Out of 1,290 respondents, 1,075 voted affirmatively to activate the Foundation as an investigative body of the House of Delegates.

On December 15, 1973, an organizational meeting of the Board of Directors of the Oklahoma Foundation for Peer Review was held. In order to fund the investigative work, the Foundation's Board of Directors borrowed \$5,000 from the OSMA (approved by the OSMA Board of Trustees) and set forth a description of its mission as follows:

"We understand our mission to be one of developing information related to the operation of a PSRO-type peer review system in order that an informed decision can be made at a later date by the House of Delegates regarding the official stance to be taken by the Association with respect to this law. Through investigation and preparation, our efforts can be utilized in any event, *ie.* (1) If it is the decision of the OSMA for the Foundation to apply for PSRO designation, then we will have a substantial amount of preparatory work done toward the development of an optimum program within the constraints of the law and regulations; and, (2) If the Association should stand against participation, the work of the Foundation in analyzing the PSRO concept will provide a base from which PSRO repeal or modification, or a program of non-participation can be justified in the light of onerous rules which might compromise the quality of care or be deleterious to the rights of patients, physicians and health care institutions."

Thus, the Oklahoma Foundation for Peer Review began limited operations about four months ago.

It should be made clear at the outset of this report that the physicians who serve on the Board of Directors of the Oklahoma Foundation for Peer Review, and on OFPR committees, are not advocates of the law. Rather, as requested by the OSMA House of Delegates and approved by the OSMA Board of Trustees, they are addressing themselves to the contingency that the law may not be repealed . . . while, at the same time (as will be explained further in this re-

port), officers, staff and committees of the OSMA are addressing their efforts toward the repeal or modification of the PSRO law.

### III. ORGANIZATION AND ACTIVITIES OF OFPR:

Since most state medical societies, or their foundations, had been formally studying operational concepts of PSRO for a year or more, the Board of Directors of OFPR decided to accelerate its appraisal of the program in order to try and come abreast of other groups across the nation. The following paragraphs outline the organizational structure of the Foundation and summarize the work accomplished or underway to date:

#### A. Committee Assignments:

The OFPR Board of Directors appointed committees to carry out major aspects of the investigation, *ie.* (1) Steering Committee; (2) Constitution and Bylaws Committee; (3) Organization and Operation Committee; (4) Committee on Guidelines for Care; (5) Committee on Liaison With Other Health Organizations (6) Committee on Contingency Plans; and (7) Committee on Professional Education.

#### B. Constitution and Bylaws Amendments:

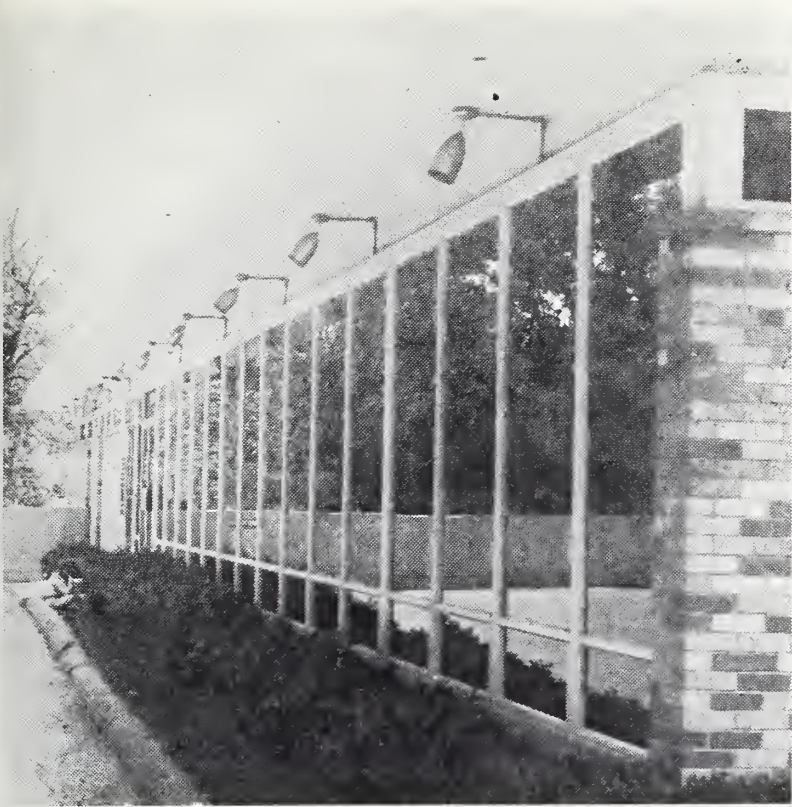
It has been determined (but no action has been taken) that the Constitution and Bylaws of the Oklahoma Foundation for Peer Review, as adopted in 1971, will have to be amended in certain respects in order to comply with the federal definition of a qualified PSRO organization.

Amendments need to be prepared: (1) To include Doctors of Osteopathy as members of the Foundation; (2) To provide for D.O. representation on the Board of Directors of OFPR; and (3) To change the manner in which members of the Board of Directors are elected (under the present bylaws, the OSMA Board of Trustees elects the Directors . . . this must be changed to provide for general elections by the entire Foundation membership).

These amendments, and perhaps others, can be accomplished quickly, but no action has been taken pending instructions from the House of Delegates.

(Continued on Page 222)





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*C. Liaison With Other Health Organizations:*

As implied in the preceding paragraph III. B, the original concept of the OFPR did not envision that the law would require MD's and DO's to participate in PSRO through the same Foundation. Our meetings with representatives of the Oklahoma Osteopathic Association have been fruitful and congenial. They supported our successful argument that Oklahoma should not be divided into multiple PSRO districts, and their attitudes and concerns with respect to the PSRO law are the same as ours.

Regarding the integration of Doctors of Osteopathy into the Oklahoma Foundation for Peer Review, we have reached a gentlemen's agreement, pending House of Delegates approval, that three voting memberships on the OFPR Board of Directors be accorded to DO's and that three officers of their association be granted ex-officio (non-voting) status on the Board. If this plan is approved, the OFPR Board of Directors would be comprised of 21 physicians (12 MD's and 3 DO's with voting privileges, and 3 physicians from each organization in ex-officio capacities).

*D. Organizational and Operational Concept:*

Because of the need to act expeditiously and expertly in developing a visualization of the impact of PSRO on the practice of medicine in Oklahoma, it was decided to retain a computer systems analyst with operational experience in the field of medical peer review. There are not many firms with this background and expertise in America.

After a series of interviews, it was decided to employ the Dikewood Corporation of Albuquerque to write a report which would outline a working PSRO-type concept for Oklahoma. Dikewood has extensive medical peer review experience in New Mexico, and is also under contract for programs in Florida, New York, Montana, Colorado, Arizona, and Oregon. The corporation was recently employed by the American Association of Foundations for Medical Care to provide the computer system for a program to establish six PSRO prototypes across the country.

The OFPR Committee on Organization and Operation, and/or the OFPR Board of Directors, have met with Dikewood executives on three

occasions to discuss optimum ways to establish a program within the concept of the PSRO law.

The resultant Dikewood report is herewith transmitted to the House of Delegates for its information and action.

*E. Guidelines for Care:*

The OFPR committee assigned to this project first obtained and analyzed the "standards, norms and criteria" developed elsewhere in the country for medical peer review purposes. These guidelines, as explained in the Dikewood report, would be used to (1) ascertain the medical necessity of health services, (2) to establish the target length-of-stay and (3) to assess the quality of care . . . all required elements of the PSRO law.

After reviewing all available guidelines (those used in Texas, Kentucky, Utah, Ohio, etc.), the OFPR committee decided to use the guidelines developed by the Academy of Medicine of Cleveland, Ohio as the basis for constructing a manual of guidelines which would be acceptable in Oklahoma.

All acute general hospitals in the state were advised of this effort in January and were asked to supply a list of the 20 most common diagnoses (10 medical and 10 surgical) by a deadline of March 1st.

The 47 hospitals which responded prior to the deadline were sent the model guidelines for the 20 medical and surgical procedures reported, and were asked to provide a critique to the OFPR. In addition, all organized specialty societies in Oklahoma (17) were supplied with the guidelines applicable to their special interests and, again, a critique was requested.

From this feedback, the OFPR committee will develop a manual of Oklahoma Guidelines for Care which may be used in any future negotiations with the government with respect to PSRO.

Samples of the Ohio guidelines are attached as Appendix A.

*F. Other Activities:*

OFPR committees dealing with Contingency Plans and Professional Education have not been activated as yet. At the present time, the OSMA itself is very active in exploring the contingencies of PSRO repeal or modification. However, both of these committees will play important roles if a decision is made to become



involved in PSRO operation.

#### IV. PSRO DEVELOPMENTS:

Local and national developments of significance may be summarized as follows:

##### *A. PSRO Designation for Oklahoma:*

On September 1, 1973, the Department of Health, Education and Welfare conducted a hearing in Oklahoma City regarding the PSRO districting of Oklahoma. Federal guidelines stated that a PSRO district could encompass no more than 2,500 physicians, whereas the combined population of MD's and DO's in the state numbered nearly 3,200 physicians. All vested interest health groups were present for the hearing, but the principal testimony was presented by C. Riley Strong, MD, OSMA President, who argued in favor of a single statewide PSRO. His position was supported by Scott Hickerson, DO, President of the Oklahoma Osteopathic Association. Subsequently, Oklahoma was named as a single statewide PSRO district.

##### *B. AMA Mid-Winter House of Delegates Meeting:*

Last December, at the Anaheim meeting of the AMA House of Delegates, a major effort was made to alter the position of the AMA toward PSRO. Delegates from Oklahoma, Louisiana, California, Indiana, Michigan, New York, Georgia and others inserted new language into an AMA report with the apparent attempt to launch an AMA effort to repeal PSRO. However, nothing was stricken in the report so amended, and the result invited an interpretation by the AMA Board of Trustees. As a result, the current official position of the AMA includes: (1) Guidance in PSRO rule making; (2) Assistance to medical societies in PSRO implementation; (3) Identification and dissemination of the deleterious potentials in the law; (4) Preparation and promotion of amendments to clarify and improve the law; (5) Continuing assessment of the political viability of PSRO repeal; and (6) As a last resort, a major effort could be made for direct repeal of the PSRO law should conditions warrant such an attempt.

The Oklahoma Delegation to the aforementioned AMA House of Delegates meeting felt certain that, in spite of the semantics and a

rather confused effort to alter the AMA's course, it was clearly the "intent" of the Delegates to direct the AMA to undertake repeal immediately. To support the Oklahoma interpretation of the intent of the Delegates, the OSMA President and the Chairman of the OSMA Board of Trustees, M. Joe Crosthwait, MD, are polling the AMA Delegates as to their "intent" at the Anaheim meeting. To date, 84 AMA Delegates have agreed with the Oklahoma interpretation of the action, while 66 have supported the interpretation of the AMA Board of Trustees.

It is certain that a major effort will be made at the next AMA House of Delegates meeting (June 23-27) to adopt a policy toward PSRO which will require no interpretation.

Meanwhile, the number of state medical societies seeking repeal through their own efforts is growing. In addition to Oklahoma, they include Illinois, Louisiana, Georgia, Texas, California, Indiana and Nebraska. The Texas Medical Association is trying to raise more than \$1 million to finance a campaign.

##### *C. AMA Amendments to PSRO Law:*

The American Medical Association, in following its policy toward PSRO, will soon be attempting to change the character of the law through a series of amendments . . . some repealing sections of PSRO in their entirety, and some designed to alter existing language contained in PSRO in a beneficial manner. The amendments are now being drafted in bill form for introduction into Congress, and it is expected that state medical associations will be included in lobbying efforts to gain passage of the amendments. A hearing on the amendments before the Senate Finance Committee has been promised in April.

##### *D. OSMA Assessment of Repeal Viability:*

Doctor C. Riley Strong, OSMA President, has contacted the entire Oklahoma Congressional Delegation to ascertain their attitudes toward repeal. At this writing, commitments for repeal have been obtained from Senator Henry Bellmon (introduced bill to repeal on March 21st), Senator Dewey Bartlett, Representative Happy Camp and Representative Clem McSpadden (introduced bill to repeal). All responses to Doctor Strong's letter have not been received, but a

(Continued on Page 225)



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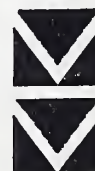
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final report can be presented at the House of Delegates meeting on April 6th.

#### *E. PSRO Planning and Development Funds:*

On March 18, 1974, the OSMA and the OFPR received regulations (published March 4th) from the Department of Health, Education and Welfare concerning the availability of federal funds to plan and develop a PSRO implementation plan which would lead toward designation as a "Conditional PSRO." In other words, funds are available to assist doctors in a given PSRO district to finance activities necessary to develop an application for PSRO designation.

The conditions of the 6-month contract would provide that the applicant organization undertake such activities as:

1. Show evidence that the organization is a non-profit, tax-exempt, corporation composed of MD's and DO's whose substantial function is to qualify for and carry out PSRO activities.
2. Demonstrate by the end of the contract period that at least 25% of the practicing physicians in the area would participate in the program.
3. Adopt as the primary function of the organization to qualify as a "Conditional PSRO."
4. Develop a technical plan to carry out PSRO functions, including methods and manpower.

The regulations do not reveal, nor will government representatives speculate on the amount to be awarded in a given PSRO district. However, it is generally conceded that it would take at least \$30-\$40,000 to develop an operational concept to the degree required by the planning contract (the preliminary Dikewood plan accompanying this report cost \$2,000).

The contract would be on the basis of cost-reimbursement, and no penalty clause is imposed if the applicant organization does not extend its activity beyond the 6-month contract period to the point of applying as a Conditional PSRO. Of course, during the contract period, the conditions of the contract would have to be pursued in good faith if costs are to be reimbursed. Funds already expended to date by the Oklahoma Foundation for Peer Review would not be reimbursed.

The deadline for initial applications is April 30, 1974. After the first group of applications have been received and acted on, it is anticipated that additional applications will be solicited after July 1, 1974.

#### *V. OSMA OPTIONS:*

Based on current developments, some of which are outlined in the preceding section, the PSRO situation now is confused . . . no formal regulations have been issued by the government as to the specific operational requirements of a PSRO . . . what appears to be the beginning of a groundswell for outright repeal of the law is building among state medical societies . . . the AMA is looking optimistically toward passage of its amendments to change the character of the existing PSRO law (*ie.* "repeal by amendment or substitution in lieu of direct repeal") . . . and conservative elements of organized medicine will seek to aim the AMA on a direct repeal course at the June meeting of the national association's House of Delegates in Chicago.

It should be noted, too, that even if the PSRO portion of the law (Section 249F) is repealed outright (which the AMA feels is not politically viable at the present time) there are at least three other sections of the Social Security Act, Sections 207, 213, and 229 which authorize the Secretary of HEW to invoke other cost controls through expanded utilization of review activities (under these provisions, the Secretary tried unsuccessfully to require precertification of all elective Medicare and Medicaid admissions in January). The AMA is seeking outright repeal of these sections which invoke "peer review" cost controls under non-professional direction.

One thing is certain. There have been "cost overruns" in Medicare and Medicaid, programs which are now costing nearly \$20 billion a year. The predicted advent of some form of National Health Insurance within the next few years will increase federal outlays for health services anywhere from \$10 billion to \$80 billion a year, depending on the proposal finally adopted. There is no visible opposition to the idea of National Health Insurance in the U.S. Congress or elsewhere . . . the arguments are over what form it should take. It is not difficult to predict, therefore, that the government will invoke some form of cost controls on an investment of this magnitude . . . so, here again, regarding PSRO, it appears that the argument is not so much whether it will be done, but what form should cost controls take and under whose direction. At this moment, PSRO is the law and it appears wise to deal with it as such unless and until it ceases to be the law or is significantly altered.



With these thoughts in mind, the following options have been advanced as to the course the OSMA should take with respect to PSRO:

*A. Adopt a Policy of Non-Participation:*

*Comment:* Some physicians feel that immediate rebellion against a punitive law would be the most effective way to achieve a better peer review system or to perhaps avoid the concept altogether. Others feel that a rebellion may indeed be eventually necessary, but argue that adopting a policy of non-participation prior to implementation, or prior to exhausting all avenues of changing or repealing the law, would place the profession in an untenable public relations position. There is growing support for repeal efforts, but immediate declarations of non-participation are not being widely advocated by state and county medical societies.

*B. Attempt to Control PSRO by Immediate Application for an Operational Contract:*

*Comment:* This option is not politically timely nor is it possible from a practical standpoint. Planning costs to construct a program suitable for application purposes are at least \$50,000.

*C. Establish a Professionally-Acceptable Alternative to PSRO Which Would Be Unassailable in Meeting Cost and Quality Control Objectives:*

*Comment:* This concept, which has been recommended by the AMA House of Delegates, is appealing but perhaps impractical from a financial standpoint. If PSRO is not repealed, it is not conceivable that the government would accept state-by-state versions of private peer review programs as an acceptable alternative to the federal law. Moreover, physicians have only until January 1, 1976 to pick up their option to operate PSRO (then it may go to any public or non-profit group). Finally, the Dikewood PSRO concept outlined in the accompanying report would cost \$2 million a year to operate, and even a scaled-down version would be tremendously expensive to fund privately. Insurance companies are not likely to help fund a program operating outside of federal law, and other donors (besides physicians) cannot be envisioned.

*D. Continue To Study PSRO and Related Developments:*

*Comment:* This seems to be the most logical course to follow at the present time, especially with a fluid situation as to the repeal and amendment efforts. Moreover, while informal rules as to PSRO operational aspects are generally known at the present time, the fact remains that no formal operational regulations have been issued at this writing. There is no uniform national sense of direction established by state medical associations . . . the AMA is strapped with a national policy which is not supported in all medical jurisdictions . . . and efforts will be made at the next AMA House of Delegates meeting to adopt a national policy more representative of the majority of constituent associations.

If the option of continued study is adopted, it should be noted that the funds of the Oklahoma Foundation for Peer Review are virtually exhausted, and an effective assessment of PSRO's impact on the profession and the public cannot be carried out without expense, especially since formal regulations will likely require alterations in the operational program, additional meetings, and other costs associated with keeping abreast of breaking developments.

## VI. RECOMMENDATIONS:

The following recommendations are an effort to encompass various *contingency plans* in dealing with PSRO:

*A. Modification or Repeal of PSRO:*

1. It is recommended that the Oklahoma State Medical Association cooperate in the AMA program to alter the character of the PSRO law in a beneficial manner.

2. It is recommended that the Oklahoma State Medical Association seek to achieve a total commitment from the Oklahoma Congressional Delegation to repeal the PSRO law as it presently exists.

3. It is recommended that the OSMA Delegation to the American Medical Association seek to alter AMA policy in a manner which would require the AMA to inspire, coordinate, and assist repeal efforts to be carried out by state medical associations.

4. It is recommended that the OSMA House of Delegates authorize the association's Board of



Trustees to invoke a membership assessment (and stipulate the amount) to carry out a public information program and/or to pay for Congressional liaison expenses if deemed necessary by the Board.

#### *B. Dikewood Report:*

1. It is recommended that the operational concept of PSRO in Oklahoma, as developed by the Dikewood Corporation, be accepted by the OSMA pending further developments.

#### *C. Continued Study of PSRO:*

1. It is recommended that the Oklahoma Foundation for Peer Review be authorized by the OSMA House of Delegates to continue to study the PSRO law and forthcoming regulations on behalf of the physicians of Oklahoma, with final authority to implement an operational PSRO-type program remaining vested with the House of Delegates.

2. It is recommended that the House of Delegates authorize the Oklahoma Foundation for Peer Review to amend the Foundation's Constitution and Bylaws to include Doctors of Osteopathy as required by law (*ie.* the Board of Directors of OFPR would be composed of 12 MD's and 3 DO's as voting members, and 3 representatives from each association as ex-officio members).

3. It is recommended that the Oklahoma Foundation for Peer Review be authorized to amend the Foundation's Constitution and Bylaws to provide for the general election of the Board of Directors (under existing procedures, the OSMA Board of Trustees elects the OFPR Board of Directors, a situation not accommodated by the PSRO regulations).

4. It is recommended that the Oklahoma Foundation for Peer Review be authorized to apply for a planning contract to finance further development of a PSRO operational concept, with the clear understanding that such contract does not carry a penalty clause if such studies do not result in an application for designation as a Conditional PSRO. (By action of the House of Delegates, the OSMA Board of Trustees may authorize application for the contract after July 1, 1974, if deemed advisable at that time.)

Respectfully Submitted By  
Board of Directors  
Oklahoma Foundation for Peer Review

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## AN OVERVIEW of THE FEASIBILITY OF PSRO IN OKLAHOMA

Final Report

*Submitted to*  
*Oklahoma Foundation for Peer Review*  
*Oklahoma City, Oklahoma*

March 26, 1974

THE DIKEWOOD CORPORATION  
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### I. INTRODUCTION

Public Law 92-603 has mandated the formation and operation of Professional Standards Review Organizations as part of the management structure for Medicaid and Medicare. The right of physicians to implement this law through PSROs which they control has been preserved until January 1, 1976. This report is intended to outline the objectives and requirements of the law and prospective Federal guidelines, as they are presently understood, and to present a conceptual method for Oklahoma physicians to establish an operational PSRO.

It is not the purpose of this report to exhaust the arguments pro and con of the PSRO concept nor to describe in detail *the* system to be used by an Oklahoma PSRO. It is intended that the reader will gain a general understanding of how PSRO will work in Oklahoma, and of what steps must be taken to assure that an operational state will be reached expeditiously with max-



imum control retained by the physicians of the State.

## II. REVIEW OF PSRO LEGISLATION

Section 249F of P.L. 92-603 states that its purpose is "to assure . . . that the services for which payment (is made) will conform to appropriate professional standards for the provision of health care . . . and that payment for such services will be made . . . only when, and to the extent (that such services are) medically necessary as determined in the exercise of reasonable limits of professional discretion." It goes on to state specifically that services should be provided on an inpatient basis only when they cannot ". . . effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type . . ."

The objectives of the PSRO are thus rather clearly laid out as providing assurance that services are being provided most economically without sacrifice of quality — and furthermore, that only physicians can make the kinds of deci-

sions necessary to achieve this assurance.

The intent of Congress can be deduced from the statements of the bill's backers. The reason for the law is clearly a combination of concerns about quality and concerns about costs, and perhaps can be simply summed up in the expression, "getting your money's worth." Furthermore, there is recognition that ordinary administrative controls can't work because non-professionals cannot recognize quality. Thus, the intent is to charge the community of physicians with the responsibility to find the facts about health care practices, to determine where the public is, and where it isn't, getting its money's worth, and then to do something about it—to take action—mostly to solve problems, but also to inform and assure the public that the situation is in hand.

The law takes more than fifteen pages of rather small print to get this idea across, and in the process, attempts to define restrictions, interactions with claim payment operations, appeals, financing, types of review, organizational requirements, sanctions, penalties and a national management structure. In the course of this narration, the law opens up for discussion a wide variety of subjects related to control of

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medical practice, many of which are rightful causes of concern to medicine. By the time regulations for implementing the law are proposed, amended and adopted, further causes for concern will have been raised, but it is clear now that the best course for physicians to follow is to work within the basic framework of the law, adopting and strengthening its positive and constructive features and helping to prevent misuse or abuse of those features that could lead to serious damage to the effectiveness of health care delivery as we know it.

Recognizing that official Federal regulations for the operation of PSROs do not yet exist, the following essential guidelines can be deduced from the law and the preliminary work of the National Professional Standards Council, a body of physicians designated by law as the principal policy-makers, and the Office of Professional Standards Review, an organization within the Department of Health, Education and Welfare that has been set up to administer the law.

1. Until January 1, 1976, only a non-profit, professional association representing a substantial proportion of the practicing physicians in an area can qualify as a PSRO. A qualified organization is one which:

a. is a nonprofit professional association (or a component of such an association);

b. is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the established PSRO area;

c. includes as members a substantial proportion (*ie.*, 25% or higher) of all licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the area;

d. provides for voluntary membership and is open to all doctors of medicine or osteopathy in the area without any requirement of membership in or payment of dues to any organized medical society or association;

e. does not restrict the eligibility of any member for service as an officer of the PSRO or eligibility for assignment of duties of the PSRO;

f. is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which PSROs have review responsibilities; *and*

g. the Secretary finds, on the basis of his examination of a formal plan submitted to him by the organization (as well as other relevant data and information), is willing and capable of per-

forming in an effective, timely and objective manner and at reasonable cost, the duties, functions, and activities of a PSRO required by or pursuant to Title XI of the Act.

2. To be designated a PSRO, a qualified organization must submit a formal plan describing its organization, management, and review system in detail.

a. Designations will be announced and, if more than 10 percent of area physicians object to the organization, a poll of area physicians will be taken. A majority of physicians voting in the poll is required for the designation to stand.

b. Initially an organization will be given a conditional PSRO designation. This conditional status will be for no less than 12 months and no more than 24 months. The purpose of this conditional designation is to make a PSRO prove itself through performance before it can become a fully designated PSRO.

3. The PSRO is *required* to review services furnished in and by hospitals and other health care institutions, such as skilled nursing facilities. First attention is to be given to acute care hospitals. The PSRO *may also*, at its option and with approval, review other types of health care such as ambulatory care.

a. The PSRO is required to retain and consult with other health care practitioners, such as dentists and podiatrists, to assist in review of such other services.

4. The PSRO is *required* to regularly review institutions, physician and patient profiles in order to analyze patterns of care, and must therefore have full access to the information to develop such profiles.

a. The PSRO *must* develop and use professional norms, standards and/or guidelines for its own area to help its evaluation of health care practices.

b. The PSRO *must* rely on those in-house utilization review committees which it finds to be operating satisfactorily, and *must* therefore be able to evaluate such U.R. committees desiring this option.

5. The PSRO *has the authority*, at its option, to approve in advance the medical necessity of elective admissions, and *must* extend its review activities to approval of length-of-stay.

6. The PSRO *must* carry on educational activities to assist providers in meeting PSRO requirements and to improve public understanding of effective health care practices.

7. In paying Medicare and Medicaid claims,



fiscal agents are required to abide by PSRO decisions on medical necessity and appropriateness of services.

8. Reimbursement to the PSRO of actual costs allowable under a comprehensive set of financial regulations will be carried out under an advance payment system.

9. Guidelines for data collection and processing will attempt to insure reasonable uniformity across the nation. Specific diagnostic and procedure codes may be designated later.

10. The PSRO will be held strictly accountable for confidentiality of information. (Chapter V discusses how this can be accomplished.)

11. While the law places certain limits on penalties and sanctions that can be used by the PSRO in enforcing its decisions after appeal, the actual processes to be used in such matters are largely left to the individual PSRO.

12. The PSRO will be responsible administratively to the Office of Professional Standards Review. On matters of development and application of norms, standards and criteria for care, the National Professional Standards Council will serve as a national professional data collection and distribution center and will evaluate, for the Congress, the effectiveness of the PSRO program.

### III. PROFESSIONAL REVIEW IN PRACTICE

Backers of PSRO legislation clearly state that inspiration for the bill originated with the success of Foundations for Medical Care in applying professional criteria to influence the cost-effectiveness of health care practices in their communities. As physician directed management organizations, Foundations have been attempting to strengthen the basic fee-for-service system in the face of a variety of modern-day challenges. While many kinds of professional review have marked the medical profession's concern with maintaining and improving quality over the years, it is the particular focus of the Foundations that comes closest to meeting the intent of PSRO legislation.

Foundations oriented toward operating peer review programs have used different techniques to perform quality care review. However, most of them use approaches based on the following principles of operation.

1. They define a "baseline" set of review criteria, guidelines and procedures.

2. As the data is collected, they continually test the validity of their criteria, guidelines and procedures to see that they indeed reflect the actual practice of medicine in their community.

3. They also communicate with the providers affected by their review program and pay particular attention to any provider appeals that indicate a change is warranted in the review criteria/guidelines.

4. A quality care review program is a blend between reviewing individual cases for medical necessity and appropriateness and reviewing patterns of practice to identify health care problems that can be corrected by a Foundation-sponsored education program.

5. The review of individual cases is basically a judgment process whereby a relationship is established between the latest patient services to be reviewed and the services previously rendered to that patient. This relationship is then examined for medical appropriateness and necessity by testing it against the existing criteria/guidelines.

The first such testing level is conducted by Foundation trained clerical personnel and is called examining, screening or first stage review. Here those cases acceptable under guidelines developed by physicians are identified and the others are pended for *physician* review. The reviewing physician, appointed by the Foundation Review Committee, repeats the present case-versus-history-versus-criteria test, applying his professional judgment, in order to make a review decision. Most of the time he can decide, but if he needs more information he will delay his decision until he gets it. Only in rare instances does he need to refer the case to third stage review by a panel of physicians.

6. The really exciting aspect of a Foundation quality care review program is its link with continuing medical education. Here the Foundation examines pattern of practice data (derived from the data on individual cases) to identify certain problems that can be solved by some type of education program. (As a general rule, such problems involve overutilization or underutilization.) Once the problems are identified, the Foundation can plan and implement education programs to correct them. The same information system that gave the Foundation the visibility to spot the problems in the first place can later be used to measure how well the education programs have corrected them.

The advent of PSRO has created the oppor-

tunity for Foundations to build effective quality care review programs using inpatient review as the cornerstone. The operating principles just described are essentially the same. Instead of claims, Admission Reports and Discharge Summaries become the primary data sources for reviewing individual cases. The Admission Reports contain the normal information to identify the patient, the institution and the physician(s) referring the patient to the institution. They also contain enough medical information to:

1. Determine why the patient belongs in the institution
2. Establish a *target* length of stay

Discharge Summaries identify the patient's actual length of stay — including any extensions to the target length of stay established during the admission process. They also contain enough medical information to identify the specific treatment received by the patient during his stay in the institution. Attached is an *example* of types of information data elements that could be captured on a Discharge Summary and other input documents.

It is important to note that physicians are *not* expected to be the people required to fill out Discharge Summaries on their patients. Rather, this function will be performed by medically oriented clerical personnel — much the same way PAS data is being generated now. A physician's involvement in the paperwork for elective admissions is expected to be a lot like his involvement in prescribing medications. He will tell someone what should be on the form and that person will fill it out for his signature.

In certain instances, when more information is needed to make a review decision, extra data such as diagnostic test results, patient records, etc. *could* be made available. But, with proper planning by the Foundation to define the data elements of Admission Reports and Discharge Summaries and the right kind of information system to process the data, a Foundation/PSRO can conduct an effective inpatient review program. Effectiveness is defined as the capability to review the medical necessity and appropriateness of individual cases *and* to have the visibility to identify problems for continuing medical education.

Summary Data—PSRO Review Regions

PSRO Review Region	Location	1970 Total Population	1970 Population Over 65	1972-73 # Recipients of Medicaid Services	1973 # of Hospitals	1973 # of Beds	1972-73 # of M/M Hospital Admissions	1973 # of MD's & DO's	Square Miles
I	Northeast Oklahoma, Except Tulsa County	454,614	62,427	57,101	28	3,132	35,212	345	13,346
II	Tulsa County	399,982	35,109	28,784	9	1,895	25,297	721	573
III	South/Southeast Oklahoma	361,257	56,991	55,388	28	2,076	34,580	266	17,320
IV	North Central Oklahoma, Except Okla- homa County	506,283	65,943	37,996	32	2,266	29,811	458	15,315
V	Oklahoma County	527,717	45,239	39,554	17	3,285	35,188	1,198	700
VI	Western Oklahoma	309,610	34,046	22,831	24	1,395	21,493	202	21,232
	TOTALS	2,559,463	299,755	241,654	138 <sup>1</sup>	14,049	181,581	3,190 <sup>2</sup>	68,486

Notes: <sup>1</sup> Does not include Indian Hospitals or Federal/State Hospitals not reporting Medicaid/Medicare Admissions.  
<sup>2</sup> Does not include 159 Federal Doctors.

Table 1



#### IV. NEEDS AND PREPARATIONS TO DATE IN OKLAHOMA

Oklahoma's 2,559,463 persons make it the 27th largest state in population, while it is 18th in land area. Its average population density of 37.2 persons per square mile is well below the national average and its two major cities emphasize the contrast between urban and relatively sparsely settled rural areas. It is the fourth largest state in population to be designated a single PSRO area.

1970 census data shows that 299,755 people in Oklahoma are 65 or older. These senior citizens can be considered as insured under Title XVIII Medicare — Part A. (Probably a very large percentage of these Part A eligibles also are insured under Medicare — Part B.)

Last fiscal year 241,654 persons received medical assistance under the State's Title XIX Program (Medicaid). When one combines these Medicaid recipients with the Medicare eligibles, it means that the State PSRO will be responsible for reviewing the inpatient care for about 20% of the State's population. In fiscal year 1972-1973, data shows that the Oklahoma Medicare/Medicaid population generated approximately 181,000 hospital admissions.

Last fiscal year \$113.9 million was paid for all medical services provided under the Oklahoma Medicaid Program. Of this sum, \$31.7 million was spent for hospital care rendered to Medicaid recipients. The remaining Medicaid expenditures can be grouped as follows:

1. Physician Services — \$16.8 million
2. Nursing Home Care — \$61.3 million
3. Other Medical Care — \$4.1 million

Hospital charges paid under Medicare — Part A are estimated to be \$60.7 million. Combining this figure with the \$31.7 million paid to hospitals under Medicaid, the 181,000 Medicaid/Medicare admissions can be equated with \$92.4 million paid out of Medicaid/Medicare hospital services during the 1972-1973 fiscal year.

The health care resources to serve the State's Medicaid/Medicare populations include 138 hospitals having 14,049 total beds. Oklahoma also has 14 Federal/State hospitals (*eg*, Indian hospitals, VA hospitals, State Mental hospitals, etc.) with 4,868 beds. However, for purposes of this report, these Federal/State hospitals were *not* included *unless* there was some data to show they had treated Medicaid/Medicare patients during the last fiscal year.

The physician resources available to treat Medicaid/Medicare patients include 3,190 MD's and DO's. These are also the doctors *available* to participate in a statewide PSRO Program.

#### Area I Breakdown

County	Total Population	Population Over 65	# Recipients of Medicaid Services	# of Hospitals	# of Beds	# of M/M Admissions	# of MD's & DO's	Square Miles
1. Osage	29,750	3,977	2,220	3	78	1,719	13	2,272
2. Pawnee	11,338	2,085	971	2	49	1,015	8	561
3. Creek	45,532	5,908	4,398	3	212	3,592	25	936
4. Okfuskee	10,683	1,846	1,692	1	39	829	7	637
5. Okmulgee	35,358	5,648	6,119	2	145	3,630	24	700
6. McIntosh	12,472	2,089	2,530	0	0	0	9	608
7. Muskogee	59,542	8,794	9,445	1	275	5,670	78	818
8. Sequoyah	23,370	2,734	4,444	1	50	1,934	9	696
9. Cherokee	23,174	2,812	2,775	1	50	1,214	10	756
10. Adair	15,141	2,081	3,859	1	36	1,518	7	570
11. Wagoner	22,163	2,480	2,714	1	50	879	7	563
12. Mayes	23,302	3,357	3,428	2	87	2,150	15	648
13. Rogers	28,425	3,029	2,105	1	71	1,739	18	685
14. Washington	42,302	4,562	2,138	1	311	2,750	57	424
15. Nowata	9,773	1,732	1,266	1	42	1,040	5	537
16. Craig	14,722	2,478	1,260	2*	1,398	1,306	25	764
17. Ottawa	29,800	3,869	3,040	3	174	2,238	22	464
18. Delaware	17,767	2,946	2,697	2	66	1,989	6	707

Table 2

\*Note: The State Mental Hospital in Vinita (1,352 beds) was included because 219 Medicare admissions were reported.

### Area III Breakdown

County	Total Population	Population Over 65	# Recip- ients of Medicaid Services	# of Hospitals	# of Beds	# of M/M Admissions	# of MD's & DO's	Square Miles
1. Haskell	9,578	1,488	2,098	1	45	1,146	6	602
2. LeFlore	32,137	4,863	6,697	2	237	2,430	21	1,560
3. Latimer	8,601	1,215	1,409	1	40	580	4	737
4. Pittsburg	37,521	5,345	3,827	1	190	3,617	36	1,241
5. Hughes	13,228	2,699	2,226	2	79	879	10	807
6. Coal	5,525	1,047	929	1	20	546	2	526
7. Atoka	10,972	1,566	2,088	1	37	1,187	7	991
8. Pushmataha	9,385	1,644	1,946	1	52	1,384	6	1,420
9. McCurtain	28,642	4,001	5,809	1	55	2,324	11	1,800
10. Choctaw	15,141	2,670	3,838	1	72	1,590	4	778
11. Bryan	25,552	4,190	3,242	1	84	2,483	11	889
12. Marshall	7,682	1,488	1,319	1	50	1,165	5	366
13. Johnston	7,870	1,467	1,645	1	60	1,130	3	638
14. Pontotoc	27,867	4,338	2,957	1	172	2,717	32	714
15. Garvin	24,874	3,899	3,891	2	95	2,139	16	814
16. Murray	10,669	1,997	1,553	1	58	1,135	7	423
17. Carter	37,349	5,607	5,406	3	295	4,427	50	830
18. Love	5,637	947	731	1	30	470	5	513
19. Stephens	35,902	5,047	2,835	4	175	2,619	25	891
20. Jefferson	7,125	1,473	942	1	30	612	5	780

Table 3

Again, for the purpose of this report, this figure does *not* include an additional 159 physicians on a Federal payroll.

Tables 1 through 5 in Section V contain regional and county distributions of the 138 hospitals and 3,190 physicians.

Anticipating the need for a strengthened peer review program under the auspices of the Oklahoma State Medical Association, the Oklahoma Foundation for Peer Review was formed in 1972. The OSMA Board of Trustees elects the Foundation Board with representation being distributed according to physician population over the state. An organization of seven committees designed to start the Foundation and bring it to operational status has been set as follows:

1. *Steering Committee*: To be the same as the Board of Directors of the Foundation for Peer Review. All other committees would report to the Steering Committee, or an Executive Committee of the Steering Committee.

2. *Constitution and Bylaws Committee*: This committee would only need to be two or three Foundation Directors. Amendments should be prepared to conform to the PSRO law in the areas of DO representation in the Foundation, and in the manner in which the Foundation Directors are elected (presently, the Directors are elected by the OSMA Board of Trustees, a

feature which is probably not compatible with present government attitudes, and would not be acceptable to the Oklahoma Osteopathic Association).

3. *Committee on Organization and Operation*: This is a priority committee, which should investigate and develop plans for the following:

a. Assess the institutional involvement and claims volume in the light of determining the needed capacity of a data processing system.

b. Evaluate alternate computer application systems for mass screening of data, in the light of selecting an optimum system for the peculiar needs of Oklahoma within the framework of the Foundation structure.

c. Develop a sound concept for PSRO implementation in Oklahoma which would likely be compatible with forthcoming regulations. Simplicity of operation and minimal aggravation to physicians, patients and institutions should be primary objectives. Confidentiality of records should also be of prime concern. A process flow chart to illustrate the preferred concept should be made, and all other operational matters should be identified and thoroughly analyzed in advance of the receipt of federal regulations and federal prototype recommendations.

4. *Committee on Guidelines for Care*: This is a priority committee. Liaison should be estab-



lished with all medical specialty groups and with other professional groups whose services are covered under Medicare and Medicaid. The purpose of the committee is to utilize the input of special interest groups in developing preliminary norms, standards and criteria *to be used as guidelines* in carrying out the requirements of the PSRO law (medical necessity, length of stay, quality and site of care). A standardized format should be developed and definitions of terms should be provided, in order that all special interest groups will be reporting and recommending in a uniform manner. The committee will have the responsibility to obtain the material from special interest groups, to evaluate special interest input for objectivity, to negotiate adjustments (if necessary) and to compile a manual of guidelines for the consideration of the Steering Committee.

5. *Committee on Liaison with Other Health Organizations:* Meetings should be held with other organizations whose members will be included in the PSRO program for the purpose of acquainting them with the law and proposed implementation plans, and to receive input from them in order to accommodate their ideas in every possible way.

6. *Committee on Contingency Plans:* In the alternative to assuming a role of leadership in PSRO implementation, this committee would evaluate the prospects of PSRO repeal or mod-

ification (or a program of non-participation) and would develop recommendations regarding these courses of action.

7. *Committee on Professional Education:* Plans for a continuing, effective professional education program would be developed by this committee. Planning for methodology and necessary personnel would be the major activities.

It is intended that the Foundation will be the basis for a PSRO. Certain changes in structure must be made to conform to the law and federal regulations. Membership must be open to all MD's and DO's regardless of their membership in OSMA or the Oklahoma Osteopathic Association. The Board cannot be elected by the OSMA, but by the Foundation's membership. Agreement has already been reached that the Board will consist of 12 MD's and three DO's as voting members.

Once the Foundation is operational as a PSRO, it would move forward — guided chiefly by the policy actions of the three key committees:

1. *Committee on Organization and Operation* would evolve into a Review Committee responsible for the appointment of Review Physicians and setting policy for their work.

2. *Committee on Guidelines of Care* would continue as the body responsible for modifying the initial Guidelines as data is compiled clarifying patterns of practice in Oklahoma. As the PSRO takes on responsibility for other types

#### Area IV Breakdown

County	Total Population	Population Over 65	# Recip- ients of Medicaid Services	# of Hospitals	# of Beds	# of M/M Admissions	# of MD's & DO's	Square Miles
1. Alfalfa	7,224	1,596	466	1	36	324	3	570
2. Grant	7,117	1,389	309	1	7	201	2	1,007
3. Kay	48,791	7,028	2,482	3	246	3,254	58	950
4. Major	7,529	1,220	315	1	23	443	2	963
5. Noble	10,043	1,701	623	1	28	308	5	743
6. Garfield	56,343	7,268	4,346	3	495	5,623	76	1,054
7. Payne	50,654	5,071	2,374	2	168	2,686	45	694
8. Logan	19,645	3,301	1,956	1	51	644	10	751
9. Kingfisher	12,857	1,851	390	2	63	785	12	904
10. Blaine	11,794	2,029	967	2	119	982	11	917
11. Canadian	32,245	3,561	1,674	1	44	880	18	897
12. Caddo	28,931	4,030	3,907	2	85	1,855	16	1,272
13. Grady	29,354	4,579	3,333	1	156	2,530	30	1,096
14. McClain	14,157	1,933	1,319	1	42	898	5	573
15. Cleveland	81,839	5,320	2,898	3	329	3,095	108	527
16. Lincoln	19,482	3,259	1,861	3	55	1,158	11	973
17. Pottawatomie	43,134	6,548	4,134	2	221	2,360	35	794
18. Seminole	25,144	4,259	4,642	2	98	1,785	11	630

Table 4

### Area VI Breakdown

County	Total Population	Population Over 65	# Recip- ients of Medicaid Services	# of Hospitals	# of Beds	# of M/M Admissions	# of MD's & DO's	Square Miles
1. Cimarron	4,145	449	199	1	20	337	2	1,843
2. Texas	16,352	1,478	573	1	62	822	10	2,062
3. Beaver	6,282	677	136	1	38	429	3	1,790
4. Harper	5,151	708	230	2	59	557	6	1,041
5. Woods	11,920	1,916	494	2	64	698	5	1,298
6. Woodward	15,537	2,010	713	2	126	1,496	20	1,251
7. Ellis	5,129	911	220	1	73	891	7	1,242
8. Dewey	5,656	970	471	—	—	—	2	1,018
9. Roger Mills	4,452	716	369	1	15	288	1	1,140
10. Custer	22,665	2,688	1,745	3	198	1,974	20	980
11. Beckham	15,754	3,118	2,212	2	97	2,620	15	907
12. Washita	12,141	2,010	910	1	35	657	6	1,009
13. Harmon	5,136	999	707	1	32	488	2	545
14. Greer	7,979	1,773	1,117	1	40	934	6	633
15. Kiowa	12,532	2,457	1,705	1	50	1,576	7	1,027
16. Jackson	30,902	2,869	3,141	1	107	2,284	18	810
17. Tillman	12,901	2,078	2,079	1	52	1,107	5	901
18. Comanche	108,144	5,031	5,158	2	327	4,335	63	1,084
19. Cotton	6,832	1,188	652	—	—	—	4	651

Table 5

of health care, this committee will again be responsible for setting the basis for review decisions in those areas.

3. *Committee on Professional Education* would carry out the educational program, dealing directly with problem physicians and institutions as well as disseminating information of broad interest. Educational efforts directed to the public and their elected representatives will be a special part of this committee's continuing work.

An Advisory Council to the PSRO, anticipated in the Foundation's Bylaws, will afford representation to allied health care providers such as hospitals, nursing homes, dentists, podiatrists, etc. Non-physician professionals must participate actively in setting criteria for care in their fields and in review activities.

It is anticipated that many Oklahoma hospitals will wish to work with the PSRO by accepting responsibility for reviewing, under PSRO policy, the care provided in their own institutions. It is believed that present performance of Utilization Review Committees varies widely among the hospitals of the state, but it is the intent of the Foundation, acting as the PSRO, to delegate review responsibility wherever the will and the capability to perform satisfactorily exists. Some specific plans of this kind are discussed in the next Section.

Preliminary discussions have been held with

the Medicaid and Medicare administrations and Fiscal Intermediaries in Oklahoma. Medicaid of course, is administered and operated by the State's Department of Institutions, Social and Rehabilitation Services, while Medicare, Part A is administered by Blue Cross of Oklahoma and Medicare, Part B by Aetna Life and Casualty Company. Expressions of cooperation from these organizations indicate that ways can be found to obtain needed information from their data systems, and in turn to transmit any decisions affecting claim payment to them. No specific methodology for carrying out these intentions has been discussed, but should be included in a formal plan for PSRO implementation.

### V. A RECOMMENDED PSRO PROGRAM FOR OKLAHOMA

Review of inpatient services occurs in three stages, (1) initial certification, (2) concurrent review and extension certification, and (3) retrospective analysis. The primary purpose of initial certification is the setting of a target length-of-stay and, where applicable, the approval of the necessity of admission. Concurrent review and extension certification includes monitoring patient progress to determine the degree to which patient care follows PSRO guidelines, determining whether the target



length-of-stay will be met, and certifying an appropriate extension of stay where complications or additional diagnostic information indicate. Retrospective analysis includes the careful evaluation of patterns of care provided by institutions and practitioners described by the data accumulated case by case. This analysis in turn produces the visibility to generate education programs as required.

The first two stages of review are highly patient oriented and will generally be most effective when performed as close to the patient as possible. To accomplish this in Oklahoma requires some type of regionalization of these review operations. However, regionalization must be accomplished in a way that maintains ultimate statewide authority of the PSRO. Retaining the third stage, retrospective analysis, at the state-wide level is a method of accomplishing this goal.

#### *Concept of Review Program*

Before moving to a discussion of regional organization and management, a brief discussion of the elements of the three stages of operation as they are conceived for the Oklahoma PSRO seems in order.

1. *Initial Certification:* In this stage the necessity of admission is verified and a target length of stay is established. Certification will take place as soon as possible after the patient has been admitted. PSRO criteria for necessity of admission, as established by the Committee on Guidelines, will be quite general but will be aimed at such goals as assuring that diagnostic admissions are for procedures that could not be carried out in an ambulatory setting, and requiring evidence of the necessity of certain surgical procedures (such as Tonsillectomy, Hysterectomy, etc.). The PSRO will have the authority to withhold certification and then to deny payment for services provided more than 24 hours after certification was denied. The PSRO will have the authority to require repeated violators of the criteria to apply for certification prior to admission if it desires to do so. Such violators might be either patients, physicians or hospitals. Admission problems are expected to be minimal since experience of other programs has shown at least 98% of all admissions to be certifiable once the program is in operation.

The next principal task is a simple one — the assignment of the target length of stay in accordance with PSRO Guidelines. The formality of setting a target has been found to be an effective way to ensure that this important cost factor is not treated too casually. It has also been a substantial contributor to improved quality by forcing physicians whose practices vary to discuss with each other their reasons for confining patients for different periods and comparing their overall results. Both practice patterns and guidelines for length of stay have been changed as a result of these exchanges.

The processes included in this step will be carried out by a Registered Nurse or other suitable personnel in a role of interpreting and applying guidelines provided by physicians, in this case the PSRO. This Nurse Coordinator will approve the admissions and set the length of stay. If she doubts the appropriateness of the admission, in the light of her guidelines, she will refer the decision to a Physician Advisor. Only he can deny admission.

The work must be carried on in or very near the hospital environment. In those cases where a hospital has accepted and been assigned its own review responsibility, the Nurse Coordinator will be an employee of the hospital and the Physician Advisor will be a member of that hospital's medical staff. Where the PSRO retains operational responsibility, the Nurse Coordinator will be a part-time or full-time employee of the PSRO and the Physician Advisor will be appointed by the PSRO and paid as a consultant to it. He may serve hospitals other than those where he has staff privileges.

2. *Concurrent Review and Extension Certification:* During this step the patient care is monitored and compared with PSRO guidelines. It is also where extensions of the target length of stay can be resolved. Patient care guidelines for this step are frequently referred to as "model treatment" guidelines. They are the most difficult to complete and require the most painstaking evolution in practice. Operations will undoubtedly begin while these guidelines are still in their infancy and this step will be devoted primarily to data collection and confirmation of the need for extensions to length of stay. The Nurse Coordinator will be the principal data collector, having access to the patient record, etc. and she would refer all questionable requests for extension to her Physician Advisor.

It is in this step that the greatest leeway in policy remains with the Oklahoma PSRO. The



type and extent of quality guidelines are not now and are not likely to be set by Federal Government.

3. *Retrospective Analysis*: This is the step where data collected in the other two steps is compiled and added to data collected from the Fiscal Intermediaries. Patterns of medical practice by institution or physician will be described in several regular reports, which will be produced on a schedule to illuminate both problems and changes that take place. Medical care evaluation studies will be carried on by the PSRO review and education committees using these reports and special reports they may call for from time to time.

Some special studies may be requested on a national basis to help describe the variance in practice across the country.

This is the phase of operations reserved for professional consideration of results, definition of problems, and redirection of the first two steps to attempt to deal with such problems. It will be carried out on a statewide basis by the key committees of the PSRO and their administrative staff.

In summary, the concept of review is one of bringing case-by-case certification and review as close to the scene of the action as possible, while maintaining review policy formulation and final decision authority in the statewide PSRO itself. Hospitals, willing and able to carry out PSRO policy within their own structure, will be authorized to do so. Otherwise PSRO staff and physicians will carry out these phases as well. All certification and concurrent review programs, whether or not carried out within the hospital structure, will provide the same data to the PSRO for use in statewide medical care evaluation studies and standard practice-pattern reporting.

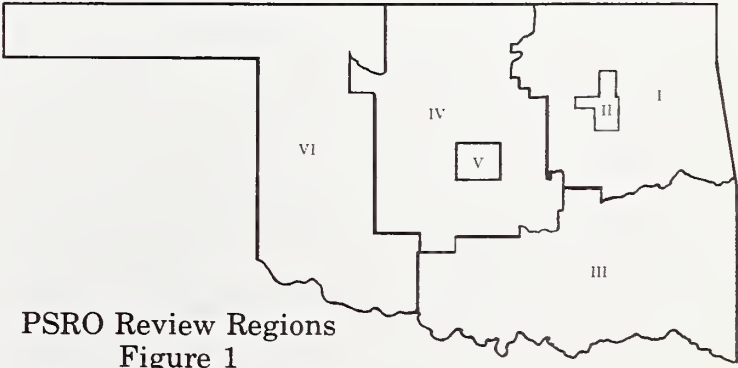
*Organization for Review*

The Oklahoma Foundation for Peer Review has always contemplated regionalization of review with the recognition that operations within the two major urban centers will deal with conditions of geography, hospital size, distribution of physicians, etc. that are widely different from the rest of the state. Given the concept of review discussed above, further steps toward defining appropriate review regions can be considered. Final regional designation may, of course, be reserved until further operational details are defined.

However, at this time, considerations of the distribution of hospitals, physicians and Medicaid/Medicare admissions lead to a suggested division into six regions as shown in Figure 1. Important statistics associated with these regions are shown in Table 1, and the breakdown of the regions by county are shown in succeeding tables. These county breakdowns were prepared to provide the visibility necessary for redefining PSRO regions as may be desired. However, no county is split in this plan, and Oklahoma and Tulsa Counties stand alone as two of the six regions.

The percentage of population concerned with Medicare and Medicaid varies from about 16% in the two metropolitan areas, Regions II and V, to about 31% in the South/Southeast non-urban area, Region III. Since Region III has the fewest physicians for its Medicare/Medicaid population (about 2 per 1,000) and almost the fewest for its total population (about 7 per 10,000), it is reasonable to expect that medical practice will have a number of differences from, particularly, the urban regions where there are about 13 physicians per thousand Medicare/Medicaid eligibles and almost 21 per 10,000 in the total population. It is because of these and other differences that all Regions will be represented on the key PSRO committees, and that some regional modifications of guidelines are to be expected.

Figure 2 shows the structural outline of an organization designed to carry out the Oklahoma concept of review. Each Regional Review Center operates under the guidance of the Regional Review Team, consisting of that Region's members of the three key PSRO committees. Assigned Hospitals, that is those hospitals to whom review responsibility has been assigned, in a Region will operate independently within the Region according to the Region's guidelines, administered under the policy of the Regional Review Team. Exceptions for special conditions within a single hospital environment will be negotiated with the Reg-





ional Review Team. Those hospitals not operating their independent review systems will be served by one or more Physician Advisors appointed by the Regional Review Team and Nurse Coordinators employed by the PSRO through its Regional Review Center.

Before leaving this subject it seems appropriate to make a few observations about non-physician staffing — particularly in hospitals:

1. The information so far indicates that *all* PSRO administrative costs will be paid by the Federal Government. Naturally, this would include the salaries of any part-time or full-time non-physician personnel working for the PSRO. This feature should be especially useful in planning ways to use, on a part-time basis, the available non-physician resources in rural areas having small hospitals with few Medicaid/Medicare admissions.

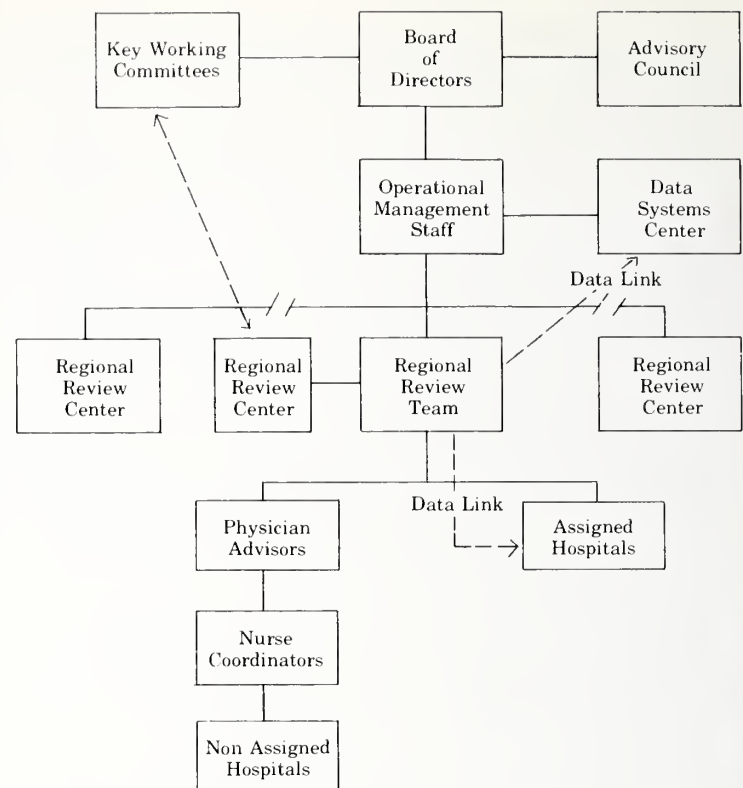
2. No hospital should have to absorb any costs of participating in the State's PSRO Program. How they will be paid or reimbursed for providing support to the PSRO is not clear at this time. One possibility would be to act as a subcontractor to the PSRO. Another method being discussed is to include PSRO support in cost reimbursement formulas they negotiate with Medicaid/Medicare Fiscal Intermediaries.

3. In any case, the PSRO should be in a position to work out a plan with all its hospitals so that none would end up being in the PSRO Program at their expense. Indeed, for the larger PAS Hospitals, they might find that PSRO allows them to consolidate certain administrative jobs and with PSRO paying its share of the costs, the hospital's total administrative cost picture could be improved.

Regional Review Centers and, where necessary, Assigned Hospitals will be linked to the PSRO data center as described below.

#### *Data System Support*

The data system to support an operation developed along these lines will consist of a centralized data bank containing all information in the state but connected to all regional offices, and perhaps to some individual hospitals by cathode ray tube terminals operating over leased telephone lines. The principal method of operation will feature entry of admission and extension certification data through the remote terminals and centralized entry of data pro-



PSRO Organization Structure  
Figure 2

vided from fiscal intermediaries. Data from discharge summaries will probably be entered into the data bank from the regional centers, but later design refinements could dictate that this data entry task be carried out by the State PSRO Center.

In each Regional Review Center appropriately designated personnel will be able to interrogate the central data bank through a terminal, and have patient, physician or institutional profiles displayed immediately in the local region. The ability to have this information printed locally can also be part of the system.

At this point it is appropriate to briefly discuss how the PSRO can preserve the confidentiality of this kind of a medical data system. In a system using terminals to enter and retrieve data (called an on line system), the people who operate these terminals will have individual call up codes assigned to them by the PSRO. These codes can be structured so that only certain people will have access to certain kinds of information. By combining the technical capabilities of the computer to operate in this manner with the PSRO's prerogative to assign the right codes to the right people very tight control over *access* to information on a "need to know" basis can be established and maintained by the PSRO. This control can be further reinforced by legislation prohibiting anyone from subpoenaing information from the PSRO.

It is true that a PSRO will have to produce

reports for government agencies (eg, OPSR). However, all the evidence thus far shows that the only information desired by these agencies would be in summary form. In no case should a PSRO be required to release information about a particular hospital, physician or patient.

A set of regular analysis reports for each region and for the state as a whole will be produced centrally and mailed to the regional offices. Special Medical Care Evaluation studies will be carried out by the Central Office staff and supported by the central computer assistance group.

Although this report does not discuss the details of the data support system, it is important to emphasize the relationship of one data process function to the overall integrity and accuracy of the data support system. This function is the coding of medical information (ie, diagnoses, procedures, etc.) into machine readable language. Two ingredients are necessary to achieve maximum coding accuracy:

1. The organization that depends on the coded medical data (ie, the PSRO) must control the coding function in order to achieve desired medical accuracy and uniformity.

The most straightforward method of control is to have the coders on the PSRO payroll. If this is not feasible or practical, then the PSRO must devise some means of checking the accuracy and performance of this critical function.

2. The data system itself should contain features and techniques which make it possible to identify and correct at least some types of coding errors before they become part of the central data base.

It is the focus of attention to this medical step of data processing that clearly delineates the requirements of the PSRO's data system from the requirements faced by most Fiscal Intermediary data systems.

To assist the Oklahoma physician community in its deliberations regarding PSRO, the following is a description of recent or near term events of interest. Estimated dates are in parentheses.

1. Draft guidelines for PSRO applicants are published and available .....March 15, 1974

2. Requests for Proposals for conditional PSRO designation and/or PSRO Planning Grants are released to first group of applicants .....(April 1, 1974)

3. Proposals for conditional designation or Planning Grants are due from first group of applicants .....(May 1, 1974)

- 4. PSRO Regulations Published .....(Summer 1974)
- 5. First PSRO and Planning Grants awarded .....(July 1, 1974)
- 6. Second round of RFP's released for Planning Grants on conditional PSRO designation .....(August 15, 1974)
- 7. Second round of proposals due .....(September 15, 1974)
- 8. Second round of contracts awarded .....(January 1, 1975)

AN EXAMPLE OF DATA ELEMENT  
INPUTS<sup>1</sup> TO AN INPATIENT  
REVIEW SYSTEM

- Hospital Number
- Patient Name
- Unique Patient Identification Number
- Social Security Number—optional in lieu of patient ID number
- Patient Zip Code
- Race
- Sex
- Birth Date
- Marital Status—optional
- Admission Type (eg, elective or emergency)
- Referred By
- Admission Date and Hour
- Payment Source(s)
- Admitting Department
- Admitting Physician
- Admitting Diagnosis
- Number of Days Initially Certified
- Number of Extensions
- Number of Days Recertified
- Discharge Date
- Attending Physician
- Consulting Physician (up to 3)
- Consultant Specialty (1 for each consultant)
- Number of Consultations
- Surgeon
- Assistant Surgeons (up to 2)
- Diagnoses (up to 5)
- Procedures and Dates (up to 20)—charges are optional
- Discharge Status
- Discharge Disposition
- Days in ICU
- Days in CCU
- Complications (up to 3)



<sup>1</sup>Notes:

- a. More than one form would produce these data elements (*eg*, Admission Report, LOS certification, Discharge Summary).
- b. Common diagnoses and procedures can be pre-coded.

Appendix C

These norms are general guidelines. In any specific case, a physician may deviate from them on the basis of his professional judgment. Such deviation does not necessarily imply inadequate medical care.

DIABETES MELLITUS

- I. Indications for Admission
  - A. Poorly controlled diabetes
  - B. Diabetic acidosis, hyperosmolar coma, lactic acidosis
  - C. Insulin coma or shock; severe or frequent hypoglycemia reactions
  - D. When complicating care of other diseases or conditions; *eg* pregnancy, trauma, elective operation
  - E. Symptomatic complications, neuropathy, nephropathy, retinopathy, vascular diseases
  - F. Requirement for patient education
  - G. In insulin dependent diabetes, for diagnostic procedures that interfere with diabetes control, *eg* upper gastrointestinal series and other procedures requiring oral fasting
- II. Services Recommended
  - A. Fractional urines for sugar and acetone
  - B. Blood sugar determinations initially and in conjunction with fractional urines
  - C. Renal clearance as indicated
  - D. Chest x-ray
  - E. X-ray of abdomen
- III. Services Consistent with Diagnosis
  - A. Quantitative proteinuria
  - B. Serum lipids and lipoprotein electrophoresis if one or more lipid fractions elevated
  - C. Urine culture
  - D. Glucose tolerance test
- IV. Length of Stay
  - A. Uncomplicated: Five to fourteen days
  - B. Difficult: Ten to twenty days

- V. Complications Extending Stay
  - A. Difficulty in obtaining satisfactory control
  - B. Advanced diabetic complications
  - C. Infections
  - D. Extreme liability of diabetes
  - E. Insulin allergy, insulin resistance, etc.
- VI. Indications for Discharge
  - A. Adequate regulation of diabetes
  - B. Maximal benefits obtained concerning complications

Appendix C

These norms are general guidelines. In any specific case, a physician may deviate from them on the basis of his professional judgment. Such deviation does not necessarily imply inadequate medical care.

CHOLECYSTITIS — BILIARY DISEASE

- I. Indications for Admission
  - A. Acute abdomen requires hospitalization for evaluation
    - 1. Nausea, vomiting, dehydration, pain of gall bladder colic
    - 2. History of recurrent pains or gall bladder attacks
    - 3. Fever associated with above symptoms
    - 4. Jaundice
    - 5. Present tenderness and pain in right upper quadrant
    - 6. Leukocytosis
  - B. Diagnosis of gall stones or nonfunctioning gall bladder already established, patient is admitted for cholecystectomy
- II. Services Recommended
  - A. History and physical
  - B. If no surgery performed (uncomplicated)
    - 1. Complete blood count
    - 2. Urinalysis
    - 3. Chest x-ray
    - 4. Liver function study
    - 5. Gastrointestinal series and cholecystogram
    - 6. Electrocardiogram when indicated by history or physical findings
  - C. Additional services
    - 1. Cholangiograms, intravenous or percutaneous
    - 2. Pancreatic function tests
    - 3. Serum amylase and appropriate blood chemistries

- III. Length of Stay
  - A. Unoperated—two to six days
  - B. Operated
    - 1. Cholecystostomy—seven to nine days
    - 2. Cholecystectomy — seven to ten days
    - 3. Cholecystectomy with exploration of common duct—eight to 12 days
    - 4. With exploration of common duct and transduodenal sphincterotomy — nine to 12 days
- IV. Complications Extending Stay
  - A. Peritonitis—ileus
  - B. Wound infection
  - C. Pulmonary disease
  - D. Bile peritonitis
- V. Indications for Discharge
  - A. Afebrile
  - B. Wound control
  - C. Absence of complications
- VI. Procedure
  - A. Cholecystostomy
  - B. Cholecystectomy
  - C. With exploration of common duct
  - D. With transduodenotomy

#### Appendix C

These norms are general guidelines. In any specific case, a physician may deviate from them on the basis of his professional judgment. Such deviation does not necessarily imply inadequate medical care.

#### FRACTURE OF THE HIP

- I. Indications for Admission
  - A. All cases
- II. Services Recommended
  - A. History and physical
  - B. Laboratory
    - 1. Complete blood count
    - 2. Urinalysis
    - 3. Electrocardiogram
    - 4. Blood chemistry
  - C. X-rays
    - 1. Hip
    - 2. Chest
    - 3. Venogram as indicated
  - D. Surgery
  - E. Traction
  - F. Physical therapy

- III. Length of Stay
  - A. Ten to 21 days
- IV. Complications Extending Stay
  - A. Wound infection
  - B. Medical complications
  - C. Loss of position of fracture
- V. Indications for Discharge
  - A. Wound healing without infection
  - B. Afebrile
- VI. Procedure
  - A. Smith-Peterson nail and plate
  - B. Replacement prosthesis, hip

#### Appendix C

These norms are general guidelines. In any specific case, a physician may deviate from them on the basis of his professional judgment. Such deviation does not necessarily imply inadequate medical care.

#### BENIGN PROSTATIC HYPERTROPHY

- I. Indications for Admission
  - A. Urinary retention
  - B. Hemorrhage
  - C. Intractable infection
  - D. Azotemia
  - E. Calculi
  - F. Progressive signs or symptoms of prostatism with demonstrable obstruction
    - 1. Frequency
    - 2. Hesitancy
    - 3. Nocturia
    - 4. Slow urinary stream
- II. Services Recommended
  - A. History (general)
    - 1. Specific urologic history justifying diagnosis
  - B. Physical examination (general)
    - 1. Specific description of size, consistency and configuration of prostate
  - C. Laboratory
    - 1. Complete blood count
    - 2. Urinalysis
    - 3. Fasting blood sugar or two hour postprandial sugar
    - 4. Serology (optional)
    - 5. Serum electrolytes (optional)
    - 6. Creatinine and/or blood urea nitrogen
    - 7. Acid phosphatase (optional)



- 8. Urine culture and sensitivity (optional)
- 9. Electrocardiogram (optional)
- D. X-Ray
  - 1. Chest x-ray (optional)
  - 2. Intravenous pyelogram with post-void film
  - 3. Urethrogram (optional)
- E. Special procedures
  - 1. Medical consultation (optional)
  - 2. Cystoscopy
- III. Length of Stay
  - A. Transurethral resection: 6-13 days
  - B. Suprapubic, retropubic or perineal: 9-18 days
- IV. Complications Extending Stay
  - A. Sepsis
  - B. Hemorrhage

- C. Urinary fistula
- D. Wound infection
- E. Renal failure
- F. Epididymitis
- G. Urinary retention
- H. Urinary extravasation
- I. Incontinence
- J. Medical complications
- V. Indications for Discharge
  - A. Adequate voiding
  - B. Absence of symptomatic infection
  - C. Absence of gross bleeding
  - D. Stable renal function
  - E. Healing wound
  - F. Physical condition permitting care in home situation or extended care facility
- VI. Procedure
  - A. Transurethral resection
  - B. Suprapubic prostatectomy
  - C. Perineal prostatectomy

## DEATHS

CHARLES P. BLUNT, MD  
1918—1974

A Tulsa physician since 1966, Charles P. Blunt, MD, died February 17th, 1974. A native of Virginia, Doctor Blunt was graduated from the Medical College of Virginia in 1943. Following practice in Lynchburg, Virginia, Corning, New York and Saint Louis, he came to Tulsa. At the time of his death, he was Director of Health Services for the City of Tulsa.

Doctor Blunt was a member of the American Academy of Occupational Medicine and the Industrial Medical Association.

ROGER GENE JOHNSON, MD  
1926—1974

Roger Gene Johnson, MD, 48-year old Frederick internist, died in Oklahoma City, March 28th, 1974. A life-long resident of Frederick, Doctor Johnson received his medical degree from the University of Oklahoma College of Medicine in 1954. Following residency training, he established his practice in Frederick in 1956. Doctor Johnson served with the Armed Services during World War II.

CARY W. TOWNSEND, MD  
1879—1974

Cary W. Townsend, MD, retired Oklahoma City physician, died April 11th, 1974. Born in Princeton, Indiana, Doctor Townsend graduated from the St. Louis School of Medicine in 1907. He began his practice in Choctaw in 1908 and moved to Oklahoma City in 1913.

Doctor Townsend received dual honors from the OSMA—membership in the Fifty Year Club in recognition of over a half century of dedicated practice and a Life Membership showing his devotion to humanity and the medical profession.

M. M. WICKHAM, MD  
1885—1974

Retired, Norman dermatologist, M. M. Wickham, MD, died in Tahlequah on April 2nd, 1974. A native of Newcastle, Virginia, Doctor Wickham was graduated from the University of Oklahoma College of Medicine in 1926. After 39 years of active practice in Norman, Doctor Wickham retired in 1965.

## Book Review

**Practical Automation for the Clinical Laboratory.** By W. L. White, BA, FAIC; M. M. Erickson, BS, Department of Pathology, St. Louis University School of Medicine; and S. C. Stevens, BA, MA, PhD, FAIC, Assistant Professor, Department of Pathology, Washington University School of Medicine, St. Louis, Missouri, USA. Second Edition. 591 pp with 346 illustrations. Missouri. The C. V. Mosby Company. 1973 \$22.50.

There are two main reasons why the second edition is a considerable improvement on the first edition: (1), it includes automated instruments in other areas of the clinical laboratory besides chemistry and (2), the selection of authors and their consultants, who are specialists in the instrumentation they discuss, make each section very informative and practical to both the technologist and the directors of the laboratory.

The instrumentation discussed in the book is the D.S.A. 560 (Beckman Inc.), the ENI Gensaec (Electro Nuctronics Inc.), the Mark X (Hycel Inc.), the Clinicard System (Instrumentation Laboratories Inc.), Atomic Absorption (Perkins Elmer Corp.), Digicon (Sherwood Medical Industries Inc.), the Autoanalyzer Systems (Technicon Instruments Corp.), Linear Converter Systems for the Basic AA (Dynacon Division of Precision Technology Inc.), Automated Blood Banking Procedures (Technicon Instruments Corp.), Automated Serological Test for Syphilis and Automated Antibiotic Susceptibility System using Technicon equipment, Hematek, Cytotek and Histotek Slide Stainers (Ames Co., Division of Miles Laboratories Inc.), the Coulter Counter Model S (Coulter Electronics Inc.), and Computer Applications to the Clinical Laboratory (Digital Equipment Corporation). Thus, the areas of chemistry, blood banking serology, hematology and cytology are covered in this edition.

Except for the computer applications, every section includes a detailed description of the instrumentation and the mechanism of operation. However, important and helpful maintenance and trouble shooting hints are not included in every instrument discussed, *eg*, the Mark X, the Clinicard System, and Atomic Absorption. The figures and diagrams do help in understanding the instrumentation in more de-

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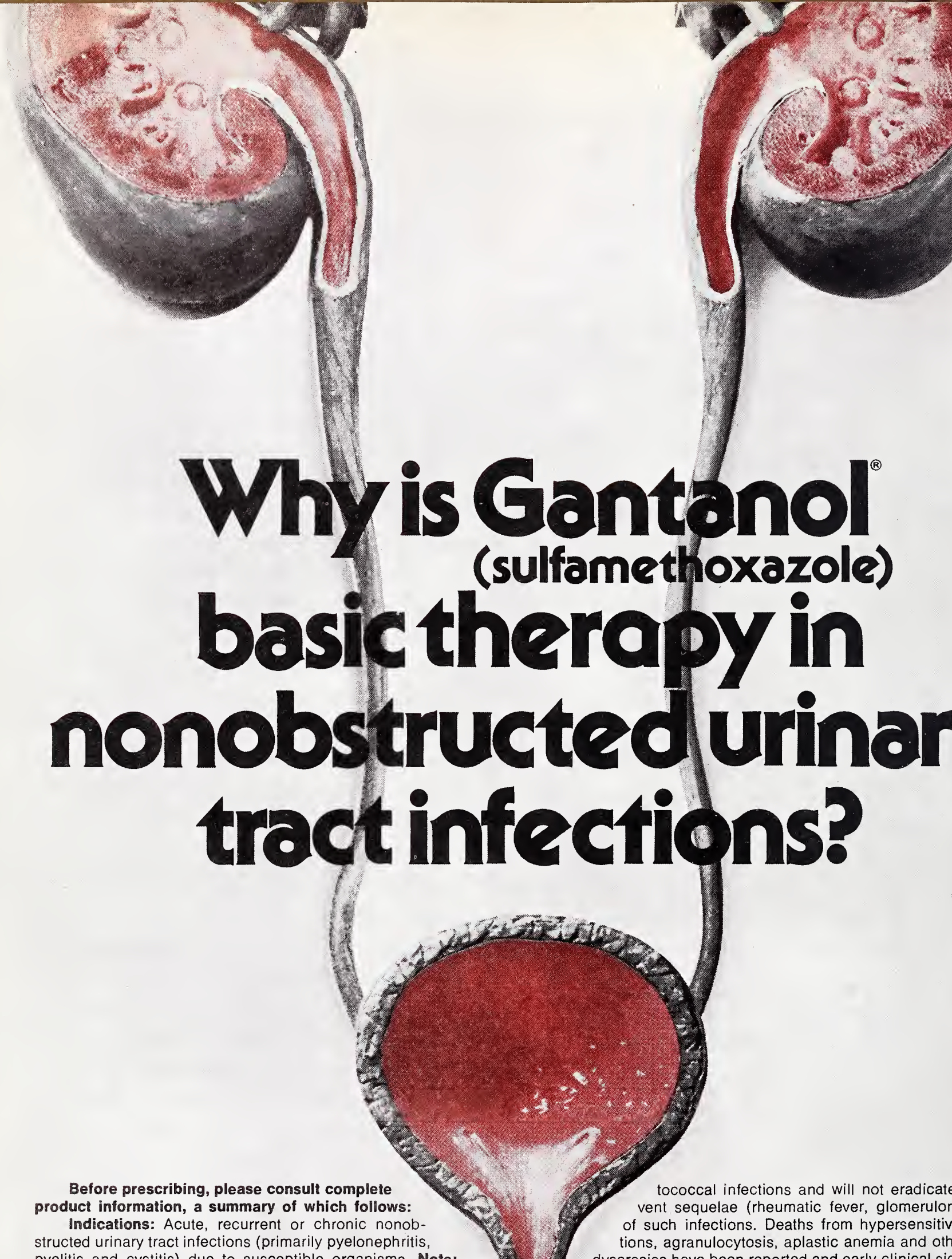
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tail. Technicon equipment is still the most dominant and is discussed in greatest detail, even to the size of pump tubing, etc. Data Processing chapter confines itself to naming the different hardware components, their functions and the input/output format. It does not go into the instrumentation, *per se*. The cost of the instrument at time of publication and a cost analysis per test or per hour of operation has not been included. It also lacks user evaluation of the instruments that are on the market. The book cannot be used to evaluate one automated instrument over another, but if you do own one of those instruments, the book serves as a rapid and easy guide to its operation especially if it is a Technicon model you are using. *Patrick V. C. Pinto, MD* ☐

(Continued on Page 246)





# Why is Gantanol<sup>®</sup> (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic strep-

tococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom drug-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, p-



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- for prompt antibacterial blood and urine levels in from 2 to 3 hours after initial 2-gram adult dose
- for economical around-the-clock coverage
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A two-day clinical symposium for physicians on "Management of Life-Threatening Problems in the Emergency Department" will be held at the Hilton Inn, Tulsa, on June 6th and 7th, 1974. The meeting will be sponsored by Saint Francis Hospital, Tulsa; the American College of Surgeons Oklahoma Trauma Committee; the Oklahoma Division of the American Trauma Society; and the Oklahoma Trauma Research Society.

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**At midnight on April 30th the Economic Stabilization Program came to an end.** In anticipation of the termination of the program, AMA leaders were asking all physicians to use "restraint" in raising fees and charges. The economic experts were predicting that health care costs would jump 16-17 percent if economic controls were dropped. Dire predictions are that physicians' fees would go up as much as 30 percent. The AMA's Board of Trustees called on all physicians to "consider the political, economic, and personal consequences of fee adjustments at this time." It is the intention of the AMA to publish quarterly regional data on the fluctuation of practice costs and inflation rates to give physicians some assistance in making decisions about fee increases.

**Abortion is far from a settled issue.** A Boston gynecologist has been indicted for causing the death of a 24-week-old fetus. The prosecutor referred to the fetus as a viable baby boy. The fetus was removed during a therapeutic abortion performed at the mother's request. Basis of the accusation comes from the Supreme Court's ruling that a state has the right to protect unborn life at the point the fetus is viable outside the mother's womb. The court stated that such viability is "usually placed at seven months but may occur earlier, even at 24 weeks."

**Carl Albert, a Democratic Oklahoma Congressman and Speaker of the U.S. House of Representatives, added impetus to the march toward national health insurance.** He joined Senate Majority Leader Mike Mansfield in a statement in which they pledge "a renewed effort toward the enactment this year" of a national health insurance law. In the statement they expressed hope that a compromise version incorporating aspects of the various plans that had already been introduced might "become the vehicle for workable solution which can be passed by both houses this year." Mansfield immediately signed as a co-sponsor of the Mills-Kennedy bill which its authors have designed as a compromise incorporating key features of leading bills already introduced.

**Here is a fact to file, but one you probably can't forget:** The Nixon Administration's \$304,000,000,000 budget when added to the total budgets that will be spent by state and local governments, means that government taxes and spends more than 44 percent of the total personal income of the American people. The \$111 billion HEW budget is almost ten percent of everything everyone earns in America.

**Nineteen out of 22 specialty boards have formerly approved "voluntary" periodic recertification examinations,** according to the American Board of Medical Specialties. The American Board of Neurological Surgery opposes the concept and the American Board of Allergy and Immunology and the Board of Nuclear Medicine have not taken an official stand. The American Board of Family Practice will make periodic recertification mandatory.

**Two Oklahoma Congressmen have now authored bills calling for the repeal of PSRO.** Senator Henry Bellmon and Representative Clem McSpadden dropped separate legislation in the legislative hopper to repeal the Professional Standards Review portions of the Social Security Act.

**Grants from the AMA-ERF to 114 U.S. medical schools total \$1,265,000 this year.** Another AMA-ERF program, the Loan Guarantee Program for Medical Students, Interns and Residents, has guaranteed 51,797 loans worth \$59,481,298 since 1962.

**Educating a medical doctor is expensive.** A health study released by the National Academy of Sciences Institute of Medicine estimates the average is \$12,650 annually per student in medical school. It costs \$8,950 to educate an osteopath, \$9,050 for a dentist and \$1,650 in associate degree nursing. The institute disclosed the results of an 18 month study to determine the average annual cost of educating a physician and seven other health professions.

**Physicians population projections indicate that by 1980 there will not be a shortage of doctors in the United States.** The total number of physicians has more than kept up with the growth of the population. It is estimated that by 1980 there will be a total need for between 413,000 and 436,000 physicians. By that year it is estimated the actual number of physicians will be greater than 436,000. □



## *Laughter From the Dock*

For twenty or thirty years I've heard that the medical profession is on trial. More recently, it's the health care system that is on trial. From time to time, the occupants of the dock have changed, but we've all had our turns . . . and more than a few. Physicians, obviously the god-fathers of the organization, have made the most frequent appearances. They are the primal felons. But hospitals, nursing homes, ambulance companies, nurses, technicians, pharmacies, drug manufacturers, blood banks, professional organizations . . . every person, every organization and every institution involved in health care has had its turn in the dock, repeatedly.

We have an army of accusers whose motives are unstated and whose objectives are unclear. Most frequently heard from are the politicians, whose motives and objectives are identical, and the most obvious; to win votes from the rapidly growing segment of our society which believes there is such a thing as a free lunch. Very recently, a group of our own politicians almost succeeded in passing a law which would force the self-supporting patients in a hospital to pay the bills for the care of all the non-self-supporting patients in the same hospital.

Amidst the cries of protest and alarm, I think I heard some laughter from the dock.

Labor organization leaders and spokesmen also make frequent and voluble appearances as our accusers. Their objectives, although somewhat veiled, are, in their own tattered words, to improve the life and lot of the great working class of the American people. Their arguments for our conviction invariably end with a demand for compulsory national health insurance. When the time comes (and it will) that such a sentence is passed, I wonder what the unions will do with their multi-billion dollar trust

funds which will then be available for their own, unrestricted use. Since none of their leaders or spokesmen have enunciated their plans, I will assume that, rather than buying politicians, they will return these monies to their members or give it to charity.

The laughter from the dock was louder this time, and not quite as conspicuous. Even the judge smiled.

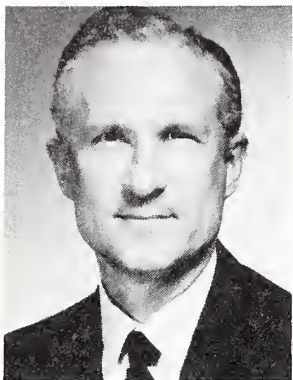
For some profoundly obscure reason, the news media of this nation are also constant accusers. Not only do they preferentially publicize the one-sided views of their co-critics, they put together their own slanted, libelous, innuendo-ridden charges. So aggressive and daring were they, on one occasion at least, the defense almost won a sustained objection. However, with an air of righteous indignation, the plaintiff successfully asserted that he was merely exercising his constitutional rights and the freedom of the press.

There was an expletive quality in the laughter from the dock.

Sometimes I get the feeling that this trial we've been enduring for the past few decades is going rather badly. Our counsel seems inept, inarticulate and, at times, even insincere. Our defense arguments have been weakly presented and unconvincing. We have a strong case but no strong defenders. Surely this is not a kangaroo court, staged and directed by ambitious, self-serving demagogues. It is a fair, impartial trial where both sides are given identical opportunities to present their arguments. There is nothing marsupial about these proceedings.

Fading away in the silence, laughter from the dock was the last sound heard in the courtroom.  
MRJ □





As I write this, the first Oklahoma Medical Summit has been completed. Its success was due to countless hours of dedicated work by many people from the three organizations, each working cooperatively and unselfishly for the benefit of all.

They are entitled to much gratitude; only those involved can possibly appreciate fully the work required. The committee members who served and your association officers and staff will meet soon for a critique to discuss ways of making your future annual meetings even better. I should like to encourage more physicians to attend and contribute to the scientific input.

Next month, your three state delegates will be in Chicago, accompanied by staff and officers, to represent your interest at the AMA. High on their list of commitments will be repeal of PSRO. This may not be as easy as it might seem locally, as thirty-nine states have agreed to cooperate with the program at this time. It is hoped that this trend can be reversed and your entire representation from Oklahoma will be working toward that end.

In our daily patient contacts and social contacts, we should all be prepared to enumerate the various disadvantages to them, the public, by government intervention in medicine and we should speak to this on every occasion possible. The public has much more to lose than do we, their doctors, but many may not realize it. They will be able to appreciate the drawbacks only in its relationship to them and we must make them understand that our aversion to a government program is for their welfare and not for ours. It is attractive to some, because it appears to be a gift, but an eighty billion dollar program (proposed by Kennedy-Mills) or a sixty billion program (admitted to by Mr. Weinberger in support of the Administration bill) can only be financed by additional taxes or by depriving other governmental programs. Someone must pay — it certainly is not free. Administrative

costs and bureaucracy will be rampant. Political influence and political appointments into executive and management positions will be based on considerations other than merit. This has already happened within HEW before the program is even underway! Government programs are notoriously inefficient compared with those of private enterprise and their histories are replete with trends of diminishing benefits while costs increase. No where in our lives is the personal relationship so important as in the doctor-patient relationship and, regardless of what the theorists contend, this will be progressively eroded. We need to remind the public that while Medicare premiums have increased the costs to the recipient almost yearly, the program has defaulted badly on original promises such as Extended Care following hospitalization and it has been denied to the patient time after time. They need to be reminded time and again of the attempts to impose pre-certification until mass response on the part of their physicians resulted in the dropping of this very restrictive and disadvantageous move. The government, while pretending to provide them increased benefits, is from the very start imposing greater loss of privileges than they have ever known before!

In 1970, by HEW's own figures, Americans made 927 million visits to physicians — about five per person. Over fifty billion dollars was spent for health care, twenty billion more than was spent ten years earlier, but most of it was through private insurance coverage. In 1971, there were over thirty million hospital admissions. On a normal day in the United States, 665,000 patients were confined in United States General Hospitals. These figures hardly support the contention that adequate medical care is lacking. Let us tell them about it very clearly and not let them at any time suffer under the illusion that we are fighting government intervention for the benefit of the doctor!

*J. L. Richardson, M.D.*

J. L. Richardson, MD

# Thrombosis of the Superior Mesenteric Vein

JAMES L. DUNAGIN, JR., MD  
M. DeWAYNE ANDREWS, MD  
ROBERT C. LAWSON, MD  
G. RAINEY WILLIAMS, MD

*A case of extensive thrombosis of the superior mesenteric vein treated surgically is reported. Selective arteriography may lead to earlier diagnosis and thrombectomy may be successful in salvaging the involved intestine.*

## INTRODUCTION

Thrombosis of mesenteric veins, with or without infarction of the intestines, is generally considered to be an uncommon entity. Diagnosis is often delayed and mortality rates remain high. Reports of instances of mesenteric venous thrombosis occurring in persons taking contraceptive medication, as well as the availability of improved methods of diagnosis and treatment are reasons for continued review of the information pertinent to this condition.

## CASE REPORT

E. M., a 53-year-old white woman, was admitted to Presbyterian Hospital complaining of

From the Departments of Medicine and Surgery, University of Oklahoma College of Medicine and the Presbyterian Hospital, Oklahoma City, Oklahoma.

mild, lower abdominal, postprandial cramping pain of one week's duration. The pain was partially relieved by defecation or enemas. Five days prior to admission, physical findings, complete blood count and urinalysis were considered normal. One day prior to admission, repeat physical examination revealed hyperactive bowel sounds and mild generalized abdominal tenderness. WBC was 9,000/mm<sup>3</sup> with a normal differential. Urinalysis, chest and abdominal x-ray films were interpreted as normal. Eighteen hours before admission, the abdominal pain became constant. Nausea, vomiting and diarrhea ensued and gross blood was noted in the stool. She was admitted as an emergency.

The patient had previously been in good health and reported no prior surgical procedures. She had taken an estrogen (Premarin, 2.5 mg daily) for eight years for postmenopausal symptoms but was on no other medication. Family history was not contributory.

**Physical Examination:** The patient was a well-developed, thin, white woman who appeared acutely ill. Pulse was 100/min and regular, blood pressure was 115/85mm Hg, respirations 16/min. and temperature was 96.6°F. Pertinent findings included slight guarding of the abdomen, especially in the lower quadrants, and hypoactive bowel sounds. Rebound tenderness was not present and no abdominal masses were palpated. Rectal examination showed the presence of blood in the ampulla. The remain-



der of the physical findings were unremarkable.

Laboratory Data: Hgb 17.2 gm/dl, Hct 55%, WBC 19,200/mm<sup>3</sup> (15 bands, 77 segs, 4 lymphs, 4 mons), BUN 27 mg/dl, Na<sup>+</sup> 138 mEq/L, K<sup>+</sup> 4.0 mEq/L, Cl<sup>-</sup> 106 mEq/L, CO<sub>2</sub> 18 mEq/L. X-rays of the chest and abdomen were unremarkable.

After hospitalization, nasogastric suction and intravenous fluid therapy were instituted and analgesics administered. Shortly after admission, the patient became hypotensive and complained of increased abdominal pain. The abdomen was distended, bowel sounds were absent and rebound tenderness was present. Surgical consultation was obtained and the patient underwent immediate exploratory laparotomy. Upon entering the peritoneal cavity, approximately 300 cc of serosanguineous fluid was found. The small bowel was edematous and deeply cyanotic. Patency of the arterial supply was demonstrated by opening a small artery in the peripheral mesentery. Numerous thrombi were found in the superior mesenteric vein extending into the very small veins near the intestinal wall. A segment of infarcted bowel, 350 cm in length, was resected and primary anastomosis made between the remaining 25 cm of proximal jejunum and a similar length of terminal ileum.

Intravenous heparin, 10,000 units, was administered in the early postoperative period and continued at a rate of 5,000 units every six hours. Moderately severe upper gastrointestinal hemorrhage began on the third postoperative day and heparin therapy was discontinued. Bleeding responded to iced saline lavage. Radioisotopic pulmonary perfusion studies performed after the onset of pleuritic chest pain showed large defects compatible with pulmonary emboli. Heparin therapy was reinstituted. Frequent loose stools and cramping abdominal pain began after the fifth postoperative day but responded to paregoric and a diphenoxylate-atropine preparation (Lomotil). Upper GI series two weeks after operation confirmed the small bowel length to be less than two feet, with a small bowel transit time of five minutes. Fecal fat content prior to discharge from the hospital was 12 grams/24 hours on no dietary restriction (normal upper limit, 7 grams/24 hours). Three weeks following admission, the patient was discharged on oral anticoagulant therapy and Lomotil for the control of diarrhea.

One year after hospitalization, the patient reported one to three solid stools daily on an

unrestricted diet. Her weight had stabilized at 111 pounds and she had resumed normal activities. Her only medication was Lomotil taken four times daily. Sixteen months after the intestinal resection, she was hospitalized for treatment of severe thrombophlebitis of the right leg from which she recovered satisfactorily. She is maintained on coumadin.

#### DISCUSSION

Obstruction of mesenteric veins with resulting changes in the intestine, ranging from edema to gangrene, is commonly encountered.

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*A 1970 graduate of the University of Oklahoma College of Medicine. M. DeWayne Andrews, MD, is presently with the Center for Disease Control, US Public Health Service. Specializing in internal medicine, Doctor Andrews will become Chief Resident in Medicine at his school of graduation in July, 1974. He is a member of the Alpha Omega Alpha.*

*Since his graduation from the University of Illinois College of Medicine in 1941, Robert C. Lawson, MD, has been certified by the American Board of Internal Medicine. In addition to his private practice he is Clinical Professor in the Department of Medicine at the University of Oklahoma Health Sciences Center. Doctor Lawson is a Fellow of the American College of Physicians, a member of the American Heart Association and the American Diabetic Association.*

*A graduate of Northwestern University School of Medicine, G. Rainey Williams, MD, has been certified by the American Board of Surgery and the American Board of Thoracic Surgery. He is presently Professor of Surgery at the University of Oklahoma College of Medicine. Doctor Williams is a member of the Board of Governors, American College of Surgeons, a member of the American Surgical Association, the American Association for Thoracic Surgery, the Southern Surgical Association and the Society for Vascular Surgery.*



Venous obstruction, with or without thrombus, is an early event in strangulated hernia and is observed when mechanical distention of the intestine becomes severe. In some instances, thrombosis of mesenteric veins is associated with recognized systemic processes such as polycythemia, cirrhosis and heart failure. Those instances of mesenteric venous obstruction due to recognized mechanical events (hernia, volvulus, neoplasms) or systemic diseases (polycythemia, etc) have been termed "secondary" venous obstruction and will not be further discussed.<sup>3, 16</sup>

Of greater interest are those cases in which mesenteric venous obstruction occurs in the absence of recognized mechanical cause or predisposing disease. This has been termed "primary" or "agnogenic" mesenteric venous obstruction and the case presented is considered to be an example of this category. It is quite unlikely that the process is the result of a single factor but, for the present, a recognizable pathologic, pathophysiologic and clinical entity can be described.

The incidence of primary mesenteric venous thrombosis cannot be calculated with any degree of confidence from existing data. It is common enough that every surgeon should be aware of the entity. The history of its description has been recorded by Berry and Bougas.<sup>1</sup>

Collective experience with this process allows several observations that may be related to cause. A high incidence of previous peripheral venous disease is commonly reported.<sup>17</sup> One family with multiple episodes of mesenteric venous thrombosis is of interest.<sup>1</sup> Recently, reports of mesenteric venous occlusion in patients taking contraceptive medication have appeared.<sup>2, 4, 5, 7, 9, 13, 14</sup> A detailed discussion of the relationship between thromboembolic phenomenon and contraceptive medication is beyond the scope of this communication, but knowledge of the suspected role of contraceptive medication in mesenteric venous disease is obviously important.

Typically, thrombosis begins in a branch of the superior mesenteric vein. The pattern of propagation of thrombus obviously determines the severity and extent of bowel involvement. Pathological studies of the condition have revealed thrombus in varying stages, suggesting that the process is an evolving one.<sup>1</sup> Microscopic

changes suggesting vasculitis have been described by Van Way, *et al.*<sup>15</sup> Grossly, there is edema of the mesentery and bowel wall. Discoloration of the bowel ranges from dusky to purple-black. There is usually a moderate amount of serosanguineous fluid in the peritoneal cavity. Perforation of the bowel occurs quite late and death of the patient is likely before perforation has occurred.

The principal pathophysiologic change in mesenteric venous obstruction is loss of fluid and blood into the mesentery and bowel. Hypovolemia, hemoconcentration and acidosis result with sepsis playing a late role. Mesenteric venous thrombosis has been produced experimentally by Polk and the pathophysiologic changes recorded.<sup>12</sup> Untreated animals died within a few hours of the production of extensive mesenteric venous thrombosis.

A diagnosis of mesenteric venous thrombosis is often delayed because of a lack of distinctive clinical features. A prodromal period, consisting of vague episodic abdominal discomfort, may last days to weeks before the onset of acute symptoms.<sup>2, 8</sup> The acute episode usually consists of persistent, severe, generalized abdominal pain. Vomiting is common.<sup>11</sup> Bloody diarrhea may occur. Ileus with abdominal distention is usually present after 24 to 48 hours.

Physical findings during the prodromal period usually are not remarkable. After onset of severe pain, examination often reveals no more than poorly localized abdominal tenderness. Later, deteriorating vital signs, abdominal distention, diminished bowel sounds and rebound tenderness signal development of an acute abdomen.

Laboratory studies show leukocytosis with a left shift.<sup>15</sup> Elevations in hemoglobin and BUN compatible with hemoconcentration may be found. X-ray films of the abdomen may show a paucity of bowel gas and a "ground glass" appearance suggestive of fluid collection within the peritoneal cavity. Free air due to perforation is an uncommon finding. A high incidence of air-filled loops of bowel suggestive of obstruction has been reported.<sup>8</sup> Polk performed selective arteriograms in animals with experimental superior mesenteric venous thrombosis. These studies demonstrated that injection of contrast material into the superior mesenteric artery resulted in reflux into the aorta, a markedly prolonged arterial phase and opacification of thickened bowel wall. Venous filling was absent. On the basis of these studies, Polk sug-



gests that selective arteriography of the superior mesenteric artery can be a valuable diagnostic tool, particularly in distinguishing between arterial and venous occlusion.

In the great majority of cases of mesenteric venous thrombosis reported to date, treatment has consisted of surgical removal of the involved intestine with re-establishment of continuity or temporary enterostomy.<sup>2</sup> Appropriate preoperative fluid and electrolyte replacement and improved general surgical support has resulted in a decreasing mortality rate. There is evidence that earlier diagnosis and operation might permit thrombectomy with salvage of the intestine. This has been demonstrated experimentally by Polk, and such a procedure has been carried out by Inahara.<sup>4</sup> The use of heparin in the immediate postoperative period is strongly supported by retrospective studies. Most authors advise the use of sodium warfarin (coumadin) for several weeks after heparin has been discontinued, but the value of such a regimen has not been convincingly substantiated. The role of antibiotics in the management of patients with mesenteric venous obstruction has also not been completely clarified. Most authors have used broad spectrum antibiotics.

The mortality rates in the management of

mesenteric venous occlusion, although reduced, remain appreciable, ranging between 40-60% in most series.<sup>2</sup> It is likely that this figure could be reduced by increased awareness of the condition, earlier diagnosis and aggressive surgical treatment.

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# Double Contrast Arthrography Of The Knee

NATHAN E. BRADLEY, MD  
WAYNE B. LOCKWOOD, MD  
MELVIN C. HICKS, MD

*A review of 86 patients using double contrast arthrograms of the knee has revealed this to be a helpful adjunct to the diagnosis of internal arrangements of the knee.*

## INTRODUCTION

Double contrast arthrography of the knee allows radiological assessment of the menisci, articular cartilages, and the ligaments. Adequate assessment of knee joint pathology requires that these structures be visualized which is best done by double contrast arthrography.

Eighty-six patients undergoing arthrograms at Presbyterian Hospital and the Oklahoma City Clinic are presented. Clinical, surgical, and arthrographic correlations are made.

## METHOD

During the time of the study the method was changed from the horizontal beam method described by Frieberger and Killoran<sup>3</sup> to the fluoroscopic method described by Angell<sup>1</sup> and Butt<sup>2</sup>. Butt suggests that to obtain sufficient detail a small-focus, under-couch tube and low kVp are necessary. Fluoroscopic control is

thought by Butt<sup>2</sup> to be essential for the following reasons:

a). In relatively normal knees the menisci can be partially demonstrated with non-fluoroscopic technic; the entire meniscus cannot be visualized. Patients with locked knees, abnormal tibial plateaus, and gross deformities cannot be adequately examined. Examination of ligaments and articular outlines requires precise positioning under fluoroscopic control.

b). Manipulation of the knee is usually necessary to adequately demonstrate the entire meniscus and to separate it from adjacent articular cartilage.

c). Extremely small variations in the angle of the incident ray will change a diagnostic film into a non-diagnostic film.

Routine anteroposterior and lateral films were made prior to the arthrogram in each case.

A surgical prep of the involved knee is done, and either medially or laterally the area of injection is infiltrated with local anesthesia. The joint is aspirated of all fluid possible, and then eight cubic centimeters of Renografin-60 and 30-40 cc of air are injected. The patient is asked to exercise the knee for 30-40 seconds.

For the purpose of filming, the meniscus has been considered to be composed of three parts: the anterior horn, the posterior horn, and the central section. Four spot films are made of each third of the meniscus with six to ten degrees of rotation after each film. This routine has been found to decrease the number of instances in



which additional films are needed. The patient's position for examining the menisci is prone-oblique with medial to lateral rotation for the medial meniscus and lateral to medial rotation for the lateral meniscus. The cruciate ligaments are examined in the lateral position with forty-five degrees flexion. The patellar cartilage may be examined in the lateral position with the knee extended and rotation toward the prone position for the lateral cartilage, and slight rotation to the supine position for the medial cartilage. The contrast medium is rapidly absorbed, and therefore films must be made fairly rapidly.

#### NORMAL ARTHROGRAMS

The appearance of the normal arthrogram is best appreciated by careful study of normal examinations (Fig 1). The menisci are visualized as sharply delineated, triangular, soft-tissue densities. The menisci are attached to the capsule completely except for the posterolateral portion of the lateral meniscus where it is crossed by the popliteus tendon in its bursal sheath.

On properly exposed lateral arthrograms the cruciate ligaments are visualized as radiolucent bands extending from their femoral to their tibial attachments.

The medial collateral ligament is not directly visualized by this procedure since it is firmly attached to the medial meniscus. The lateral collateral ligament lies outside the capsule and tears of this structure cannot be visualized. Semi-membranosus-gastrocnemius bursae are present in about twenty per cent of the cases,

and expansions of these are called popliteal or Baker's cysts, which can obscure posterior portions of the medial meniscus. The same problems occur with bursae of the popliteus tendon obscuring the posterior portion of the lateral meniscus.

#### ABNORMAL ARTHROGRAMS

Abnormalities (Fig 2) are readily detected if one is familiar with the types of normal variations encountered. An arthrographic classification of meniscal tears described by Olsen<sup>4</sup> is as follows:

A). Peripheral detachment from capsular attachment

B). Tear of the meniscus proper

1). Vertical

a). Without displacement

b). With displacement of central fragment (bucket handle)

2). Transverse or Horizontal

3). Combinations (common in extensive injuries)

If a meniscus has been previously removed surgically, there is an absence of the lucent wedge formed by a normal meniscus when surrounded by opaque medium. The degree to which this absence is complete reflects the extent of removal modified by the extent of the regrowth of the fibrocartilage. A retained posterior horn can sometimes be identified.

Meniscal cysts can only rarely be identified when they deform a meniscus. Ruptures of the cruciate ligaments can be identified by a lack of continuity of the ligament manifested by pooling of the opaque material in the gap caused by the rupture. There are a large number of inconclusive examinations of the cruciate ligaments



Figure 1. Normal arthrogram, medial meniscus.



Figure 2. Vertical tear medial meniscus.



when there is no pooling or well-outlined ligament. Fresh tears of the medial collateral ligament can often be identified if the synovial lining adjacent to the tear is ruptured, allowing escape of contrast material into the soft tissue. Synovial tumors, non-opaque loose bodies, and hypertrophied fat pads can be identified.

#### CLINICAL MATERIAL

The records of eighty-six patients undergoing eighty-eight arthrograms at Presbyterian Hospital and Oklahoma City Clinic were reviewed. There were twenty women with an average age of 36.2 years, and there were sixty-six men with an average age of 31.4 years. The overall average age was 33.1 years with a range of fourteen to sixty-seven years. The right knee was involved forty-four times, and the left knee was involved forty-one times. There was one bilateral arthrogram done. There was one repeat arthrogram which had surgery after both arthrograms, and the arthrographic diagnosis of the menisci was confirmed on both occasions.

There were twenty-three arthrograms on twenty-two patients who have not had surgery. Of these, five were thought to have meniscal lesions on arthrography, but no surgery was performed for various reasons. One of the five has returned because of continuing pain, but the clinical findings were normal, and again surgery was not recommended. One other patient had continuing crepitus but no pain, and surgery was postponed indefinitely. Of the remainder, one patient thought to have a tear of the anterior cruciate ligament clinically and arthrographically, continued with some instability. Two patients with clinical patellar chondromalacia and negative arthrograms, continued with some pain and effusion. The remainder of the patients whose arthrograms were negative have recovered from their symptoms.

Of the sixty-six patients who had surgery, there were sixty-seven arthrograms done. There were two "false positive" and eleven "false negative" meniscal lesions described by arthrography. One of the false positives and false negatives was a tear of the medial meniscus described as a tear of the lateral meniscus with a normal medial meniscus on arthrography.

At surgery, fifteen torn cruciate ligaments were found, only three of which were apparent on arthrograms. One cruciate ligament which

appeared torn in the arthrogram was found intact at operation. There were fourteen osteochondral defects or chondromalacia defects described at surgery, none of which were demonstrable on arthrogram. There were twelve popliteal cysts described on arthrograms, only one of which was found at operation.

The arthrograms of the false negative and false positive meniscal tears, the cruciate ligament tears, and the osteochondral and chondromalacia defects were reviewed.

Of the eleven false meniscal lesions, eight involved the posterior medial meniscus and none could be detected in retrospective study. Four of these cases also had popliteal cysts which might have obscured a tear. Another factor accounting for the false negatives is that films positioned far enough posteriorly to include the most posterior portion of the meniscus were not made.

None of the osteochondral or chondromalacia defects could be identified in retrospective study of the films. Films specifically designed to show the articular margins of the patella which would be necessary to reveal chondromalacia were not made. Also, only a small portion of the articular cartilages of femurs and tibiae can be seen tangentially on arthrograms.

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It is generally considered that single contrast studies are better for demonstrating the cruciate ligaments. With the described method, many cruciate ligaments can be defined. While absence of visualization of a cruciate ligament may indicate a tear, it does not mean that all non-visualized cruciate ligaments are torn.

#### DISCUSSION

Nicholas, *et al*<sup>4</sup> reported a preoperative accuracy of diagnosing meniscal tears in 3,000 cases of over 90% not using fluoroscopy. Butt, *et al*<sup>2</sup> reported over 90% accuracy using fluoroscopy. In the first sixty-seven knee arthrograms obtained in our facilities the arthrograms were performed mainly for evaluation of the menisci, and the accuracy of diagnosing meniscal tears was 80.6%. Initially fluoroscopy was not used, but subsequently fluoroscopy was not used as described above. With more experience, information regarding articular cartilage and ligament continuity can be obtained from the arthrogram.

As pointed out by Olson<sup>5</sup>, a popliteal cyst when filled with contrast medium can obscure a meniscal tear by overlapping it. Of the eighty-eight arthrograms described, 14% revealed popliteal cysts. Four of the false negative cases had popliteal cysts which in retrospect probably

obscured a tear.

As Nicholas<sup>4</sup> stated, the value of the arthrogram should be to decrease a delay in treatment. It may show double tears when only one compartment might have been explored. Often the posterior horn can be identified if it is retained. Surgery may be avoided when the arthrogram is normal, and surgery may be clearly indicated when a definite tear is revealed by arthrography even though the signs and symptoms are minimal.

#### SUMMARY

Eighty-eight arthrograms obtained on eighty-six patients are described and a review of recent articles is presented. The technique and normal and abnormal arthrograms are described. A correlation of arthrographic diagnoses, surgical findings, and results in non-surgical patients is presented.

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# Peritoneal Lavage In The Evaluation Of Abdominal Trauma

JOHN S. WATSON, MD  
PAUL F. PARK, MD

*Intra-abdominal injuries in trauma may  
not be obvious during the acute period.  
Simplified techniques are described for  
their evaluation.*

Abdominal trauma presents problems in diagnosis and management relative to its nature, timing, associated injury and the previous condition of the patient. Major and multiple system trauma is increasing in our society. Now, advances in casualty handling bring patients to treatment centers more rapidly. Complex casualties often survive to present new problems in management to community facilities.

Early recognition and treatment of abdominal injury is important. Our community hospitals need a direct, simple means of determining serious intra-abdominal injury. Various methods have been suggested; aortography and various other radiographic techniques are mentioned in the literature by Freeark and others.<sup>6,7</sup> Soloman in 1906 describes the diagnostic abdominal paracentesis done with a

ureteral catheter. An extensive report of paracentesis with multiple-hole catheters is made by Neuhof and Cohen<sup>12</sup> in 1926.

Several writers have been concerned with diagnostic peritoneal puncture.<sup>1,2,4,5,6,8,11,16,17</sup> These methods require either special equipment and training or present a high incidence of false negative results. Root<sup>13</sup> in 1965 described the peritoneal lavage; since then others have investigated this technique. Peritoneal lavage in evaluation of abdominal trauma seems to offer reliable means for diagnosis without requiring specialized equipment or advanced training.<sup>3,7,9,14,15,16</sup>

## MATERIAL AND METHODS

Twenty-one patients with either blunt or possibly penetrating abdominal trauma were studied in the emergency room of two large community hospitals during a fourteen-week period.

The patients were the victims from eight auto and two motorcycle accidents, three beatings, three gunshot wounds, two stab wounds and three miscellaneous injuries. The latter included a patient three days post-laparoscopy who suffered abdominal pain and was found to have subphrenic air and hysteria. A patient admitted with bleeding diverticulitis and in shock, later developed signs of abdominal injury and gave a history of being beaten. Another patient was impaled in the thigh by a jack-

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hammer and exhibited abnormal abdominal signs.

A history was obtained, a physical examination was performed and indicated x-ray studies were done upon the arrival of the patient. A nasogastric tube and Foley catheter were installed and routine laboratory studies were carried out. If a question of intra-abdominal organ damage existed, with suggestive but not definite abdominal signs, the patient was submitted for study. Bilateral lower quadrant paracentesis was performed with a number 18-gauge spinal needle introduced through the peritoneum. Gentle aspiration was carried out with the needle in several positions.

If the results of the paracentesis were either negative or inconclusive, diagnostic peritoneal lavage was carried out. Under aseptic conditions, an area three to four cms below the umbilicus in the midline was infiltrated with 1% Xylocaine (plain). A small incision was made in the skin and subcutaneous tissue with a number 11 Bard-Parker blade. When necessary, hemostasis was obtained by gauze compression. A multi-holed polyethylene catheter and trocar from the McGaw peritoneal lavage catheterization kit was placed in the incision against the fascia. By controlled pressure the catheter was introduced through the fascia and peritoneum into the abdominal cavity. The trocar was withdrawn and the catheter advanced inferiorly. If no blood or intra-abdominal fluid was obtained spontaneously, gentle suction was applied. If still nothing returned, then one liter of either sterile normal saline or Ringers-Lactate was instilled into the peritoneal cavity with the patient in a supine position. A few milliliters of irrigant were retained in the bottle to assure a siphon effect and a large bore needle was inserted through the stopper. The bottle was then placed on the floor to allow for fluid recovery. After recovery of a minimum of 100 milliliters of fluid, the catheter

Figure 1

#### CRITERIA FOR POSITIVE LAVAGE

Vol > 100 ml  
Gross Blood  
RBC > 100,000 (mm<sup>3</sup>)  
WBC > 500 (mm<sup>3</sup>)  
Bacteria — Pres.  
Bile — Pres.  
Amylase > 100 IU

Figure 2

	Needle Tap	P.D.L.
Number	21	21
Positive	0	7
Negative	20	13
False Positive	0	1
False Negative	6	0
Possibly Positive	1	0
Possibly Negative	0	0
Complication	0	2

was withdrawn, a dressing applied and the fluid was taken to the laboratory. Volume and color of fluid were noted and a gram stain and culture obtained. Red and white blood cell counts, as well as assays for amylase and bile were performed.

Criteria for interpretation were derived from the works of Perry<sup>13</sup>. (Fig 1) The test was considered positive if there was blood obtained by aspiration, or if the lavage fluid was grossly bloody. The finding of more than 100,000 red blood cells or 500 white blood cells per cubic millimeter, amylase activity over 100 units per cent, the presence of bile or bacteria or intestinal content constituted a positive test.

#### RESULTS

In all twenty-one patients studied (Fig 2), paracentesis results either were of doubtful value or negative, necessitating further study. In thirteen cases, lavage results were negative: They represented the victims of four auto accidents, one motorcycle accident, two gunshot wounds to the abdomen, two stab wounds, two beatings, and two miscellaneous injuries. The miscellaneous cases included a 22-year-old white woman three days post-laparoscopy. These patients had either a benign clinical course or findings at autopsy revealed no intra-abdominal lesion of surgical significance. Six patients exhibited significant injuries in other areas involving head, chest and extremities. Injuries were limited to the abdomen in the remaining six cases.

Two patients died and were autopsied: A 17-year-old white woman was involved in an auto accident, receiving a left temporal fracture, multiple rib fractures, left tension pneumothorax, pelvis fractures, and an open fracture of the left wrist. She was admitted comatose and in shock. Fluids and blood were given and a tracheotomy and left thoracostomy were performed. Hematuria was noted and the

IVP revealed retroperitoneal extravasation of contrast medium via the right kidney. Indefinite left upper and bilateral lower quadrant guarding was present. The patient was studied with negative findings before being transferred to the intensive care unit. Central nervous system status deteriorated and the patient died. Autopsy revealed 1,000 ml of organized left retroperitoneal hematoma; focal, subserosal, colonic mesenteric hemorrhage; a small hematoma in the right hepatic lobe and multiple pelvic fractures.

A 55-year-old white woman involved in an auto accident was admitted unconscious and in shock, with fractures of the mandible, left clavicle, ribs on the left and a severe avulsion laceration of the scalp. A tracheostomy was performed, fluid and blood were administered and resuscitation efforts instituted. Peritoneal study was done because of the absence of bowel sounds and lower quadrant guarding. The results were negative and the other injuries were treated. Post-operatively, a course of pneumonia, sepsis and renal failure resulted in death. An autopsy did not reveal a surgical lesion in the abdomen.

A 22-year-old white female came to the emergency room three days after laparoscopy had been performed by a gynecologist. She exhibited abdominal pain, distention, guarding, rebound tenderness, decreased bowel sounds and a hysterical effect. Laboratory studies were normal. X-rays revealed free subphrenic air. The peritoneal study was performed with only 20 ml of fluid returned seemingly due to abdominal air interference with drainage. The fluid appeared grossly normal. The patient claimed abatement of her symptoms and left the emergency room against medical advice.

Lavage results were positive in eight patients: (Fig 3), Four from auto accidents and one from a motorcycle accident, one abdominal gunshot wound, one assault victim, and one case of acute, severe lower bowel hemorrhage which presented a history of having suffered a beat-

ing. Four of these patients presented injuries limited to the abdomen and four presented significant injuries in other areas, including fractured ribs and extremities, and chest trauma.

Operative findings in those with isolated abdominal trauma included two lacerated spleens, one retroperitoneal hematoma, and two with 1500 ml of free peritoneal blood. Another patient sustained a laceration of the inferior right hepatic lobe and superior right renal pole with retroperitoneal hematoma.

Four patients presented coincident injuries in areas other than the abdomen. Operative findings included one patient with a large rent in the mesentery of the small bowel with contusion of the small bowel and cecum and the presence of 600 ml of free, intraperitoneal blood. There were three patients with lacerated spleens and free intraperitoneal blood with amounts ranging from 1000 ml to 1500 ml. The associated injuries included one patient with two open extremity fractures; another patient with multiple rib fractures; one with contusions and fractures of the mandible, and a patient with a leg fracture. In all cases of intra-abdominal injury, the diagnosis was made by a positive lavage, in spite of a negative paracentesis, and within one hour of the patient's initial examination in the emergency area. Gross blood was returned immediately from the dialysis catheter without lavage in three patients. These represented two cases with ruptured spleens, one with retroperitoneal hematoma, and one with free intra-peritoneal blood, as well as one with laceration of the liver and the superior pole of the right kidney.

A false positive test was obtained in the study of a case with severe lower gastrointestinal bleeding and shock. An unclear history of injury by beating was obtained from the patient after resuscitation. The abdomen later became distended and tender, compromising respiration. Although his bleeding had ceased, compelling

Figure 3

ORGAN SYSTEMS

Positive Lavage

8 in 7 Patients

5 Spleen

1 Kidney

1 Liver

1 Mesenteric tear

1 False Positive

---

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## Lavage / WATSON, *et al.*

signs indicated abdominal injury. The lavage was positive. Laparotomy revealed approximately 500 ml of fresh blood and clot apparently from a bleeding vessel in the fascia at the puncture site. The post-operative course was uneventful and the patient was discharged with a regimen for treatment of his diverticulitis.

Two patients with negative lavage had amylase activity greater than 100 units per cent; these being 440 and 468 respectively. A 42-year-old man with a history of excessive alcohol ingestion was stabbed above the left inferior costal margin. There was no radiographic evidence of pneumothorax or definite entry into the thorax, but inspection revealed intercostal penetration. We elected to follow the patient clinically in the absence of red or white blood cells, bile or bacteria in the lavage fluid. After hospitalization, increased serum and urine amylase activity was evident and the patient showed signs and symptoms consistent with acute pancreatitis. He responded to therapy and was discharged from the hospital in good condition.

A 55-year-old white woman accident victim exhibited a dialysate amylase of 468 units per cent, without increased white or red blood cells, bile or bacteria. Autopsy findings revealed no intra-abdominal lesion of surgical significance.

In patients with negative lavage results and a subsequent benign course, the lavage volume ranged from 20 ml to 750 ml with an average of 376 ml. In no case did the fluid show more than a pink coloration. Amylase values ranged from 9 units to 468 units per cent, RBC's ranged from 0 to 11,500/mm<sup>3</sup> and WBC's ranged from 0 to 150/mm<sup>3</sup> (Fig 4)

In patients with positive lavage results and positive operative findings, the lavage volume ranged from 300 ml to 630 ml with an average of

526 ml. Fluid color in each case was of varying shades of red. Amylase values ranged from 23 units to 60 units per cent. RBC's ranged from 100,000 to 700,000/mm<sup>3</sup> and WBC's ranged from 75 to 3,500/mm<sup>3</sup>. No bile or bacteria were noted in any case. (Fig 4)

## CONCLUSIONS

In all instances peritoneal lavage was carried out with readily available equipment, within a reasonably short period of time, with minimal expense and at an early stage of the patient's evaluation. In no instance was this associated with complications related to the lavage or the introduction of the dialysis catheter.

In one case, an unsatisfactory fluid return was obtained in a woman three days post-laparoscopy and the study was meaningless. In another case a false positive result was obtained; this occurred at the inception of the study. Others describe the insertion of the catheter with direct visualization of the peritoneum and fascia<sup>3</sup>, but the technique was modified in our study to facilitate rapid performance of the test without need for much extra equipment and to permit its execution by personnel without specialized training. The results in all cases were available early and did not delay the patient's resuscitation, evaluation and management. The data were helpful in all cases. The value of the procedure in the management for the unconscious, traumatized patient is readily evident. There was reasonable assurance of no abdominal lesion in all cases with negative results. In most patients, evidence of intra-abdominal injury was immediately available without reliance upon delayed findings such as recurrent shock, drop in hematocrit and hemoglobin, distention, rigidity, tenderness, rebound, abnormal mass, or other gross signs. In those patients with gunshot wounds and/or stab wounds, the test was performed to establish the actual event of peritoneal penetration of the

Figure 4

	VOL (ml)	RBC (mm <sup>3</sup> )	WBC (mm <sup>3</sup> )	AMYLASE (IU)	BILE	BACT.
Positive High	630	700,000	3,500	60	0	0
Low	300	100,000	75	23	0	0
Negative High	750	11,500	150	468	0	0
Low	20	0	0	9	0	0

missile or instrument in question. In no patient did paracentesis reveal the true, complete situation within the abdomen, and possibly its continued use will serve only to add a source of complication. It was noted that a continuous column of fluid within the tubing is necessary for adequate siphon effect on return of the fluid. For this reason, its use in pneumoperitoneum may be difficult or unnecessary. For technical reasons, it is thought that a return volume of over 100 cc is necessary for prevention of undue dilution of the returning fluid by the fluid remaining in the line. The establishment of base line criteria by which to evaluate a return of fluid and to form an opinion seems highly necessary and desirable. The observation of color alone is not proper, as it is subjective and other constituents might be present which are colorless. Gross blood or very bloody fluid is, however, considered positive. Certainly, variations from colorless or slightly colored solutions must be looked upon with great suspicion as indicative of serious intra-abdominal injury. The finding of high amylase values in the lavage return must be evaluated carefully in relation to the historical and physical findings and the previous physical status of the patient.<sup>10</sup> In this series an isolated high amylase value without the associated findings does not seem to constitute a criterion for necessary operative intervention. A carefully done history and physical examination are necessary in all cases.

SUMMARY

Twenty-one patients entering the emergency areas of two large community hospitals were studied (for the presence of intra-abdominal in-

jury) by means of abdominal paracentesis in conjunction with and in comparison to diagnostic peritoneal lavage. The rapid and accurate diagnosis of severe intra-abdominal injury was made possible by positive peritoneal lavage findings. The findings, when negative, enabled the deferral of abdominal surgical intervention and preferential attention to other injuries. This study is presented to display the advantages of such a technique in trauma management.

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## Tick Paralysis

A previously healthy three and one-half year-old girl from eastern Oklahoma awoke one morning and was unable to walk by herself. Her legs became so weak that she could not remain standing unless assisted. The parents promptly drove to the office of their family physician. On route the parents found an engorged tick on the girl's scalp and removed it.

A physical exam minutes later revealed a young girl with weakness of all four extremities (legs greater than arms). Deep tendon reflexes, sensory examination, and mentation were all normal. The girl had no fever, nausea, or vomiting, and did not complain of pain. She had no history of recent upper respiratory or gastrointestinal infection. The physician's diagnosis was tick paralysis (tick toxicosis). Within hours of removal of the tick, the girl was improved and was ambulatory later in the day. The tick was submitted to the Oklahoma State Department of Health and identified as *Dermacentor variabilis* (dog tick). Such bites are almost invariably inflicted by a pregnant female tick. Chil-



## News From The Oklahoma State Department of Health

dren are more frequently affected than adults, and girls more frequently than boys.

An affected patient may present with (1) rapidly progressive flaccid paralysis which is ascending and symmetrical, or (2) severe ataxia, dysmetria, and intention tremor without muscle weakness. Paralysis subsides within hours or days of removal of the tick and its mouth parts.

During the summer season, Oklahoma residents will be at increased risk of acquiring tick-borne diseases such as tick paralysis, Rocky Mountain spotted fever, tularemia, relapsing fever, and Colorado tick fever. Physicians should question patients with unexplained acute paralytic or febrile disease regarding possible tick exposures. □

### COMMUNICABLE DISEASES IN OKLAHOMA FOR APRIL, 1974

DISEASE	April 1974	April 1973	March 1974	TOTAL TO DATE	
				1974	1973
Amebiasis	2	10	2	6	13
Brucellosis	—	—	2	2	2
Chickenpox	114	233	279	528	939
Encephalitis, Infectious	4	3	3	13	5
Gonorrhea (Use Form ODH-228)	891	785	1032	3291	3451
Hepatitis, A, B, Unspecified	81	79	100	389	355
Leptospirosis	—	—	—	—	—
Malaria	—	1	—	1	1
Meningococcal Infections	4	3	2	11	7
Meningitis, Aseptic	5	11	1	14	15
Mumps	48	89	134	256	243
Rabies in Animals	21	32	13	50	70
Rheumatic Fever	—	2	1	3	7
Rocky Mountain Spotted Fever	3	4	—	3	4
Rubella	4	31	5	22	132
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	2	7	5	13	22
Salmonellosis	23	13	13	72	55
Shigellosis	12	30	4	41	70
Syphilis, Infectious (Use Form ODH-228)	12	21	21	51	73
Tetanus	—	1	—	—	1
Tuberculosis, New active	31	32	27	94	105
Tularemia	—	—	1	2	6
Typhoid Fever	—	—	—	—	1
Whooping Cough	—	2	1	5	10

## House Of Delegates Business Highlights



During its 68th annual meeting in Oklahoma City, the OSMA House of Delegates considered the reports of its six councils, four standing committees, Board of Trustees, Secretary-Treasurer, President, and twenty-six resolutions. In addition, it conducted its annual elections, reported on page 269 of this Journal.

All of the business of the association to come before the House of Delegates is considered first by one of three reference committees. Reference committees hold open hearings on each report and resolution and then recommend appropriate action for the House of Delegates to take. The following is a brief summation of the important recommendations and actions taken by the house.

### AMA MEMBERSHIP

The House of Delegates voted overwhelmingly to continue the association's policy of requiring AMA membership for its members. Two resolutions called for a change in the OSMA bylaws to make the payment of AMA dues voluntary, while one resolution required that the OSMA continue its program of mandatory AMA membership.

In adopting the report of the Committee on Constitution and Bylaws, the association changed the name of the Council on Professional Education to the Council on Continuing Medical Education.

The house also adopted a recommendation by the committee that the Executive Committee be named in the bylaws by position. The Executive Committee shall consist of the general officers of the association and the Chairman of the Board of Trustees. The general officers are defined as the President, President Elect, Immediate Past-President, Vice-President, Secretary-Treasurer, Speaker of the House of Delegates, and Vice-Speaker of the House of Delegates.

The house also changed the delinquency date for the payment of dues. The bylaws were changed to say, "Dues shall be payable on January 1st for the year on which levied, and shall become delinquent if not paid before February 1st of that year."

Qualifications for delegates and alternate delegates to the House of Delegates were also changed with the adoption of the statement that

such delegates and alternates must be "members in good standing of the Oklahoma State Medical Association." Previously, the bylaws had stated that a physician must have been a member of this association prior to his election as delegate or alternate.

THOMAS C. POINTS, MD

A special resolution submitted by OSMA President, C. Riley Strong, MD, commended Thomas C. Points, MD, for twelve years of dedicated service to his profession as an alternate delegate to the American Medical Association. The House of Delegates acknowledged Doctor Points' service from 1961 to 1973. A special plaque was presented to the doctor during the House of Delegates meeting.

### COUNCIL ON PROFESSIONAL AND INTERVOCATIONAL RELATIONS

The house approved a feasibility study on a conference on cults and quackery to be held for both medical and lay people. The conference recommendation was an outgrowth of the new "fads" in medical practice . . . acupuncture and hypnosis. The council's report expressed concern about abuses in these two areas and felt that a program of public information would be justified. The form for such an information program could well be a conference on cults and quackery.

The council also reported to the house that it has maintained liaison with the legal profession, dental profession, nursing, optometry, pharmacy, physicians' assistants, and is in the process of establishing liaison with the claimmen's association for Oklahoma. This latter is the organization of men working for insurance companies to settle claims.

### COUNCIL ON PUBLIC POLICY

A Public Relations Program for the coming year was adopted when the house approved the Council on Public Policy Report. The association's weekly health column will be converted for use in daily newspapers on a new



format more closely resembling the popular nationally syndicated health columns.

The OSMA staff was also instructed to institute a program of visiting media editors throughout the state. A regular schedule of visitations will be established so that newspaper editors, and radio and TV news directors will receive information on the association's activities.

The OSMA Speaker's Bureau will be reactivated in the Summer of 1974 for implementation on or about September 1st. A Speaker's Training Seminar will be held in the latter part of the summer and each member of the bureau will be provided with "canned" talks on a limited number of subjects. The association will then actively seek speaking engagements for bureau members. Emphasis will be placed on civic groups and service clubs located in cities of 10,000 population or more. A new descriptive brochure will be designed and topics chosen that will be of interest to the general public and worthwhile for the association.

The house also recommended that the editorial board of the association consider a "Preview Page" for the OSMA Journal. This would capsule principle scientific and news articles and would become a regular feature in the front of *The Journal*.

On the subject of legislative liaison, the house recommended that the association continue its present lobbying level in terms of one full-time staff member having this assignment as his principle duty. The Associate Executive Director, David Bickham, currently has this responsibility.

Regarding a PSRO repeal campaign, the house adopted the report of the committee in which it stated, "we concur . . . there does not seem to be any justification at this time . . . for a . . . massive and expensive public information program . . . on PSRO. However, it is the feeling of your committee that Oklahoma physicians should begin now putting into motion the machinery to inform their patients of the serious effects of government intervention into the practice of medicine."

The House of Delegates also called on all members of the association to lend their full support to Oklahoma Medical Political Action Committee.

Several different resolutions were offered to the House of Delegates dealing with the subject of Professional Standards Review Organization's repeal and what actions the members of the association should take in regard to PSRO. In dealing with one of the resolutions the house called for the Public Relations Committee to develop information to be used by physicians in their offices informing their patients deleterious affects of government intervention in medicine and that there be a general public relations effort to include information about the harmful affects of government intervention in private practice of medicine.

The house also adopted a resolution calling for the American Medical Association to institute immediate and direct action in an all-out effort to work for the repeal of that section of public law No. 92-603 that creates Professional Standards Review Organizations.

One resolution was introduced that would require the association to enter an amicus curie brief in a lawsuit that is being conducted by another national medical organization seeking to declare the PSRO law unconstitutional. A substitute resolution was introduced in its place to resolve ". . . that the OSMA Board of Trustees consider cheerfully the action of AMA at its upcoming meeting in June in regard to legal action to declare the PSRO law unconstitutional. In the event that the AMA does not take legal action to declare said law unconstitutional, then OSMA will enter into negotiations with other state medical societies and, if a substantial number concur and agree, then OSMA will join others in legal action seeking declaration of the PSRO law as unconstitutional."

The House of Delegates also adopted a resolution that would call for the imposition of PSRO type reviews on federal institutions such as VA Hospitals, Public Health Service Hospitals, Indian Health Service Hospitals and Military Hospitals.

#### HOSPITAL STAFF PRIVILEGES

Hospital staff privileges were the subject of a resolution from the Oklahoma County Medical Society. The resolution pointed out that the medical profession has traditionally opposed any requirement to pay for staff privileges in a hospital. It went on to say that quite often the

(Continued on page 266)



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failure to pay arbitrary staff dues have caused physicians to lose their privileges.

The House of Delegates adopted the policy statement, that the Oklahoma State Medical Association opposes any requirement to pay for staff privileges in any hospital except for dues that are voted and administered exclusively by the medical staff.

#### MEDICAL CENTER LIAISON

The report of the Medical Center Liaison Committee ended up by recommending that the OSMA President and the Chairman of the Committee host a meeting with the following persons: President Sharp of O.U.; Dean Robert Bird of the O.U. Medical School; Robert Mitchell, MD, a member of the O.U. Board of Regents; Don O'Donohue, MD, Chairman of the University Hospital Board of Trustees; and any others that the OSMA President might feel could add to the meeting. The purpose of this meeting would be to discuss the OSMA's liaison with the Health Sciences Center and develop an appropriate role for the association's Medical Center Liaison Committee.

As soon after this meeting as practicable, the committee should draft a report of its findings to be presented to the Board of Trustees of the association and set out a specific plan of action for Oklahoma physicians in regard to the Health Sciences Center. The plan should explain the financial condition of the center, corrective action necessary and what association members can do to help.

#### COUNCIL ON PROFESSIONAL EDUCATION

In another action by the House of Delegates, the name of this council was changed to the Council on Medical Education. This was an out-growth of a recommendation made at last year's House of Delegates by a reference committee.

This council recommended that the House of Delegates authorize it to prepare a series of regional programs on the socioeconomics of medical practice. The topics to be discussed at the regional seminars would be based on a questionnaire that was handed out during Oklahoma Medical Summit.

The council was also instructed by the house to study the feasibility of establishing an ac-

creditation program for continuing education courses. The council had received a request from the AMA to study the possibility of the OSMA establishing its own program of accreditation in continuing medical education for community hospitals, state level specialty societies, county medical societies and voluntary health agencies. Such accreditation would assure that physicians wishing to use local continuing medical education activities could apply such toward credit for the AMA's Physicians' Recognition Award.

In a related action, the House of Delegates adopted resolution No. 13 which called upon the council, in conjunction with the University of Oklahoma Health Sciences Center, and other interested organizations to develop plans to provide continuing education at the local level. Courses would be devised to meet the standards and requirements of the AMA's physicians' award and the continuing education requirements of the American Academy of Family Physicians, and other medical organizations.

The reference committee amended this resolution, which was originally authored by the Carter-Love-Marshall County Society, to provide that the association should enter into a contract with the University of Oklahoma Medical School Office of Continuing Education to formulate a plan to carry out the intent of the resolution. Such a contract should be for an amount of \$1,000.00.

#### COUNCIL ON PUBLIC HEALTH

In adopting the report of the Council on Public Health, the OSMA House of Delegates set in motion a number of different activities.

The Alcoholism and Drug Abuse Committee of the council was instructed to establish a public information program on alcoholism and drug abuse. "A speaker's bureau on these two subjects should be considered, possibly combined with a speaker's bureau for the entire association." In another action, the house adopted a plan to reactivate the speaker's bureau.

The Committee on Alcoholism and Drug Abuse was also instructed to continue to work with interested organizations in an attempt to coordinate drug abuse and alcoholism information programs throughout the state.

The association's Committee on Maternal Mortality received permission to publish a "Maternal Health Desk Book" to be distributed to all hospital delivery rooms and to all mem-



bers of the association. The desk book would outline procedures to be followed whenever a physician is faced with an obstetrical emergency.

The biggest portion of the Report of the Council on Public Health was entitled "Task Force Report on the Medical Conditions in Oklahoma's Penal Institutions." This special report was prepared at the request of Governor David Hall. It ended with the conclusion, "The most important need in the corrections department organization is a full time, qualified medical director who has the vision and initiative to implement bold programs to improve the health environment for the total prison population throughout the state. The medical director should be selected by a Health Advisory Committee named to assist the corrections department in this function."

The report also called for the creation of the Health Advisory Committee to consist of the Commissioner of Health, Director of Mental Health, Director of Medical Research Commission, Director of the Department of Corrections, the Medical Director of the Department of Corrections, the Governor, President Pro-Tempore of the Senate, Speaker of the House of Representatives, and Chairman of the Board of Corrections.

The report also offered the assistance of the Oklahoma State Medical Association in locating such a medical director or in any other way that might be appropriate for the Health Advisory Council.

A complete transcript of the entire Task Force Report will appear in the next issue of the *OSMA Journal*. Other recommendations in the report were as follows:

"An organization structure should be designed that places the medical director in full command of all personnel who are employed to provide medical or dental services or supervise programs that directly affect the medical well-being of the prisoner.

"The objectives of the Health and Medical Care Services Program should be clearly stated and periodically reviewed.

"A health care plan with operating procedures needs to be developed.

"The expenditures for medical services should be clearly delineated in the corrections department budget.

"There should be considerable exploration of the use of allied health personnel.

"An opinion needs to be requested of the Attorney General about the individual liability of

medical personnel and medical facilities when treating prisoners."

In summary the report states, "There are other worthwhile suggestions that should be considered — a centralized induction center for initial screening, a maximum security wing at the new McAlester hospital, contracts with individual physicians and facilities, but all lead to the same conclusion. The health care program of the Oklahoma Corrections Department needs direction. Thus, it is imperative that a full-time, qualified, medical administrator be employed as soon as possible."

#### COLLEGE PHYSICAL EXAMINATIONS

The House of Delegates adopted a resolution that called on the OSMA to develop a standard college entrance physical examination form and promote its adoption by Oklahoma colleges and universities for both entering and transferring students.

It was pointed out, in the resolution, that every hospital and college in the state seems to have a different physical examination form and has designed its own unique criteria for acceptable entrance examinations.

#### FOREIGN MEDICAL GRADUATES

The House of Delegates recommended that the Legislature of the State of Oklahoma empower the Oklahoma Board of Medical Examiners to establish limiting rules for the licensure of non-U.S. citizen foreign medical graduates. This would enable the Board of Medical Examiners to deal more effectively with the problem of foreign medical graduates coming into the United States for residency training programs.

#### FAMILY MEDICINE PROGRAM

The House of Delegates commended the University of Oklahoma Health Sciences Center for its support of the Family Medicine Program. However, it also recommended that the university continue improvement in both the financial support and the availability of inpatient care space for family medicine.

#### COUNCIL ON SOCIOECONOMIC ACTIVITIES

In adopting the report of this council, the  
(Continued on Page 269)



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House of Delegates amended it to provide that the functions of the OSMA Peer Review Committee be more widely publicized to association members, and that considerable work be done to explain the actual function of the committee. □

**Meet The President-Elect**

The new President-elect of the OSMA is Arnold G. Nelson, MD, of Midwest City, Oklahoma. He will serve in this capacity until May of 1975. At that time he will become President of the OSMA when Jack Richardson, MD, of Tulsa completes his term of office.



Doctor Nelson was born in Chickasha, Oklahoma, in 1921. He attended Pioneer Schools near Chickasha and then went to Clifton Junior College at Clifton, Texas.

After spending almost four years in the United States Navy, the doctor returned to college and completed his premedical education at North Texas State, Denton, Texas. He is a 1952 graduate of the University of Oklahoma College of Medicine.

In 1950 Doctor Nelson married Wanda Jo Latimer of Pauls Valley, Oklahoma and in the next few years became the proud father of four children; Amy Crosswhite, deceased, 1973; Arnold Gordon Nelson, Jr., presently a junior at Central State College; Cindy Nelson, graduating senior at Midwest City High School; Scott Nelson, a sophomore at Midwest City High School. He has one son-in-law, Leon Crosswhite, who plays with the Detroit Lions of the National Football League.

The doctor established his practice of medicine in Midwest City in 1954. He is in partnership with his friend and medical school classmate, George R. Randels, MD.

His accomplishments in medical organizations are many. He has been a member of the Oklahoma Academy of Family Physicians, and the American Academy of Family Physicians since 1955. He served as Secretary-Treasurer of the state organization for five years and has served in all offices in that organization since, capping off his career in 1966 by serving as President. He has also served as a delegate to the American Academy of Family Physicians National Congress of Delegates.

He has been a member of the Oklahoma County Medical Society for the past twenty years and served as President of the organization in 1968. For the past year he has served as Vice-President of the Oklahoma State Medical Association and had previously served as a delegate to the House of Delegates from Oklahoma County for many years.

Also during the past year he served as President of the Oklahoma City Clinical Society and was Chairman of the Scientific Program Committee for the 1974 Oklahoma Medical Summit . . . the medical meeting held in Oklahoma City May 12th-15th that was jointly sponsored by the OSMA, the Oklahoma Clinical Society and the Oklahoma Academy of Family Physicians.

Doctor Nelson is a Charter Fellow of the American Academy of Family Physicians.

He has served as Chief of Staff of the Midwest City Memorial Hospital, and is currently Chief of Surgery, Chairman of the Bylaws Committee, and Chairman of the Medical Records Committee.

The doctor is a member of the First Baptist Church of Midwest City and is active in both church and civic affairs.

He is a Past-President of the Midwest City Quarterback Club and is physician in charge of assignment of physicians for the Midwest Bomber Football and Wrestling teams, a position he has held for ten years.

Doctor Nelson will serve one year as President-Elect of the OSMA and will then become its President during the 69th Annual Meeting scheduled for May, 1975. □

**New OSMA Officers Elected During Summit**

Arnold G. Nelson, MD, emerged as the new President-Elect of the OSMA following the Association's House of Delegates during Oklahoma Medical Summit on Wednesday, May 15th. The house also selected other new officers to serve during the coming year.

Ardmore's Roger Reid, MD, was elected Vice-President of the OSMA and relinquished his long-held seat as Speaker of the House of Delegates. He was replaced as Speaker by S. N. Stone, MD, of Oklahoma City who had been Vice-Speaker of the house. The new Vice-Speaker of the OSMA House of Delegates is Jack Fetzer, MD, of Woodward.

The association's AMA representation remained the same after the elections, although



there were four positions on the ballot. AMA delegate for position number one is Harlan Thomas, MD, Tulsa. Position number two is Scott Hendren, MD, Oklahoma City. Both the AMA delegates were re-elected to their positions.

Also re-elected were the two alternate delegates, Orange Welborn, MD, Ada, in position number one and Rex Kenyon, MD, Oklahoma City, in position two.

The House of Delegates also chose some new trustees and alternate trustees for the association's board.

James Eskridge III, MD, and John Blaschke, MD, both of Oklahoma City, were elected trustees from District VI of the association. Their alternate trustees will be Perry Lambird, MD, and John Devore, MD, both of Oklahoma City.

A new trustee was named for District VII. Casey Truett, MD, Norman, will serve on the board. His alternate will be Clinton Gallaher, MD, Shawnee.

Tulsa had two trustee seats up for election. William Benzing, MD, and Paul Bischoff, MD, both of Tulsa, were chosen as Tulsa's trustees from District VIII. Their alternates will be Harold Calhoon, MD, and Myra Peters, MD, both of Tulsa.

Thomas Gafford, MD, of Muskogee will serve as Trustee for District IX and his alternate will be Burdge Green, MD, of Stilwell. □

### **Tennis And Golf Popular During Oklahoma Medical Summit**

Golf and tennis drew a great deal of interest during Oklahoma Medical Summit. Twenty-seven golfers participated in the golf tournament at Kickingbird Golf course near Edmond. Thirty tennis players participated in the tournament.

Doctors Stanley McCampbell and David Pillow took the Men's Doubles tennis tournament by defeating Doctors David Snider and Lee Ison. In the Men's Singles, David Pillow was the winner when he defeated Farris Coggins, MD. Doctor Coggins was also the coordinator for this year's tournament.

In the women's tennis events Mrs. Mary Coggins defeated Mrs. Joan McCampbell for the singles.

In the Ladies Doubles Mrs. Coggins teamed up with Mrs. Wanda Jennings to defeat Mrs. Linda Elkins and Mrs. Martha Williams for the doubles championship.

Meanwhile back on the golf course, Leon Combs came in with a low gross score of 74 on the par 70 Kickingbird Golf course. He was followed by Bill McCurdy, MD, with a 77 and Larry Silvey with a 78.

In the low net category, Doctor Charles Tollett, MD, came out on top with a score of 70 followed closely by Doctor Gary Rahe, MD, with a 71. Three doctors tied for third, each shooting a 72: Bob Taylor, Don Cooper and Dale Hughes.

Trophies were awarded to all winners in both the golf and tennis tournaments. □

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## ABBREVIATED PROGRAM

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### Thursday—July 18th

2:00 P.M. Check in and registration.  
5:00 P.M. Social hour and attitude adjustment period.

### Friday—July 19th

8:30 A.M. Registration and Continental Breakfast.  
9:30 A.M. Welcome and introductions.  
9:45 A.M. HEW's commission on medical malpractice report.  
1:30 P.M. Workmen's Compensation: Medical and Legal update.  
3:00 P.M. Professional Standards Review Organizations — Legal Implications for physicians and hospitals.  
5:00 P.M. Social Hour and attitude adjustment period.

### Saturday—July 20th

9:00 A.M. Congressional Delegation report on pending Federal Legislation  
11:00 A.M. What to do when the IRS comes.  
12:00 Noon Frosty Troy speaks.

Registration fee of \$40.00 per person includes the two social hours, Saturday luncheon, and all printed materials.

Fountainhead State Lodge has set aside a block of rooms for registrants and requests should be made directly to the Lodge, Checotah, Oklahoma.

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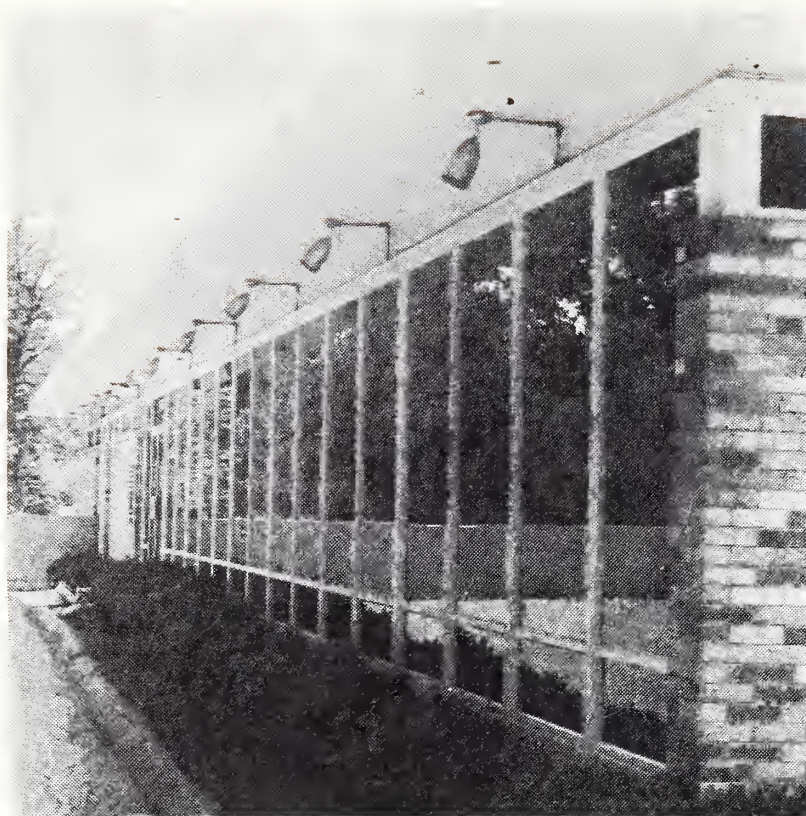
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### **Physicians Win Two Major Legislative Battles**

Barton Carl, MD, reported to the House of Delegates during its May meeting that physician-influence had resulted in the defeat of two major bills in the Oklahoma Legislature.

Both votes occurred in the Oklahoma Senate. House Bill 1291 would have permitted the plaintiff's counsel to seek information from the defendant regarding the extent and amount of liability insurance coverage. The OSMA Legislative Committee considered this a major threat in malpractice law suits.

The vote was 9 to 35 against the bill and recorded as follows:

**AGAINST OSMA:** Birdsong, Garrett, Howard, Porter, Smith, Stansberry, Stipe, Wolfe and Young.

**FOR OSMA:** Baldwin, Berrong, Boecher, Breckinridge, Capps, Cate, Crow, Dahl, Ferrell, Field, Funston, Grantham, Graves, Ham, Hamilton, Hargrave, Holden, Howell, Inhofe, Keels, Keller, Lamb, Luton, McCune, Martin, Medearis, Miller, Murphy, Pierce, Randle, Rogers, Schuelein, Taliaferro, Terrill and Watson.

Excused: Lane, Trent and Wadley.

Senate Bill 593 would likewise have affected

the association's liability insurance program. The measure would have permitted an injured worker covered by Workmen's Compensation Insurance to bring an action against his treating physician. In addition to the recovery that might be gained through the Industrial Court, a civil action could be brought. Heretofore, the courts have held that a physician, when treating an injured employee covered by Workmen's Compensation, is an agent of the employer and is therefore immune to malpractice suits. The vote was 29 to 7 against the bill, recorded as follows:

**AGAINST OSMA:** Birdsong, Crow, Funston, Grantham, Hargrave, Howard, Randle, Rogers, Smith, Stipe, Wolfe and Young.

**FOR OSMA:** Baldwin, Berrong, Boecher, Breckinridge, Capps, Cate, Dahl, Ferrell, Field, Garrett, Graves, Holden, Howell, Inhofe, Keels, Lamb, Lane, Luton, McCune, Martin, Miller, Pierce, Schuelein, Stansberry, Terrill, Trent, Wadley and Watson.

Excused: Ham, Keller, Medearis, Murphy, Payne, Porter, and Taliaferro.

Doctor Carl had high praise for the physicians who contacted their Legislator. "Proponents of the bills credited doctors with their defeat," said Doctor Carl. "Hopefully, these successes will help our members understand the



importance of personal contact with elected officials. In the final analysis, it's the physician-constituent that influences the legislator not our Committee." □

### **Physicians' Bill Of Rights Adopted By OSMA Delegates**

During its Oklahoma City Meeting on May 15th, the OSMA House of Delegates adopted Resolution No. 20, "Physicians' Bill of Rights."

This resolution was introduced by the OSMA's Committee on Planning and was based on a similar resolution from the Illinois State Medical Society. The Physicians' Bill of Rights, as stated in the resolution, is suitable for the use of physicians everywhere, and is as follows:

"1. We support the goal of making available high quality health care to all people. However, we vigorously oppose employing any means to attain this goal which would compromise the patient's freedom of choice or the physician's right to care for his patients in the manner which his training, experience and judgment dictate to be most effective.

"2. We believe physicians, as professionals, should be allowed to use their knowledge and training for the benefit of all people without government interference and harassment or relegation to the status of government employees.

"3. We reject as a matter of principle the arbitrary development of compensation guidelines for physicians' services by government and insurance companies without prior participation and approval.

"4. We reject as a matter of principle all formulas for compensation of physicians' services not based upon usual, customary, and reasonable fee concepts.

"5. As part of their responsibility to the policyholder and to the public, insurance companies and others providing coverage for medical care should specify in clear and understandable language all benefit limitations.

"6. We reject as a matter of principle insurance companies and others providing medical services coverage implying to policyholders that physicians' charges are excessive.

"7. If an insurance company questions a physician's charges, its medical director or

another qualified professional should attempt to resolve the problem by contacting the physician. If they are unable to reach an agreement, the company should present its complaint to the local medical society's peer review committee.

"8. We reject discrimination in physicians' compensation for similar services based solely upon geographic location. We contend that this discourages physicians from establishing practices in rural and other areas already severely affected by a maldistribution of the physician population.

"9. Governing boards and hospital authorities will not be permitted to unilaterally develop bylaws governing the conduct of medical staffs without the participation and formal approval of the staffs involved. Such action will result in prompt counter action, beginning with an appeal to the Joint Commission on Hospital Accreditation, legal or other steps appropriate to the situation.

"10. Only licensed physicians and dentists approved by the Medical staff shall be authorized to admit patients or discharge them from hospitals and other facilities.

"11. Complaints by patients regarding the quality and manner of care rendered by a physician should be made in writing, notarized, and submitted to the physician's local county medical society. Patients should be informed that it may be necessary to confront the accused during review proceedings.

"12. Unauthorized substitution of prescribed items will be viewed by physicians as the illegal practice of medicine and will be met with counter action, legal or otherwise as the situation warrants; and be it further

"Resolved, That this Bill of Rights becomes effective upon adoption and implementation will, if necessary, include court action." □

### **Health Sciences Center Policy Adopted By OSMA House Of Delegates**

During its 68th Annual Meeting the OSMA House of Delegates adopted an official policy statement regarding the University of Oklahoma Health Sciences Center. The statement was adopted during Oklahoma Medical Summit in Oklahoma City on May 15th.

Immediately after its adoption, the policy statement was sent to all major news media in the state so that the OSMA's position on the



Health Sciences Center and the University Hospital would be well-known.

The policy statement is as follows: "The Oklahoma State Medical Association is gravely concerned that confusion about necessary funding for the University of Oklahoma Health Sciences Center, and especially about its affiliated University Hospital, will affect the quality or availability of educational programs which are vital to the citizens of Oklahoma in terms of producing adequate health manpower today and in the future.

"The 3,300 medical doctors in the state, over half of whom are graduates of the OU College of Medicine, have not been officially involved in the management of the Health Sciences Center or in the financial studies of the past two years which have been inspired or authorized by the Governor, the Oklahoma Legislature, the University of Oklahoma Board of Regents and the Board of Regents for Higher Education. However, we can't believe that mutually agreeable solutions to the financial problems can't be found through good faith negotiations between the Governor, the Regents' groups, the Health Science Center officials and the responsible leaders of the Oklahoma Legislature. An impasse over the question of what constitutes adequate funding to sustain the education programs and to keep University Hospital open as a vital health services center for the citizens of Oklahoma will not serve any useful purpose; rather, it could result in depriving Oklahomans of needed health practitioners and health services.

"Oklahoma *must* be able to afford adequate funding of the OU Health Sciences Center . . . Oklahoma cannot afford to tolerate a financial dilemma at the expense of losing or severely handicapping the state's only complete health manpower training center.

"The Oklahoma State Medical Association is not directing criticism toward any of the parties or individuals officially involved in the current controversy. Instead, the Board of Trustees and the House of Delegates of our association are appealing to the responsible parties . . . those in positions of management and those with financial responsibility . . . to quickly take whatever steps are necessary to assure the uninterrupted continuity of essential services and training programs now underway for the benefit of our citizens.

"The association will be immediately responsive, if asked, to participate in finding solutions

to the financial problems at the OU Health Sciences Center. We have faith that all parties concerned will place the preservation of the center and related facilities above vested interests they may have." □

## **Acapulco In Winter Awaits Oklahoma Physicians**

An opportunity to avoid at least one week of Oklahoma's cold weather next January is being offered to Oklahoma physicians. The "Acapulco Winter Meeting" is being sponsored by the OSMA for its members January 15th-21st.

Physicians interested in getting away from it all for seven nights and six days at the beautiful Hotel Las Brisas in Acapulco should contact the OSMA office in Oklahoma City. A \$75 per person deposit is required and must be received no later than July 1st, 1974. The total price per person, based on double occupancy, is \$457.

The total price includes roundtrip jet air transportation, economy class, from Oklahoma City; continental breakfast each morning; seven nights and six days at the luxurious Hotel Las Brisas with its 200 swimming pools and casitas; and all gratuities to airport porters and Las Brisas staff members.

For those unfamiliar with the Las Brisas, it is the only hotel in the world where every room has a private or sharing swimming pool. There are 200 swimming pools, 122 private and 78 sharing . . . no two alike.

Although the Las Brisas is a hotel, it has no lobby and there are no elevators. A fleet of 150 pink and white jeeps are used to transport guests throughout the hotel area. Each family has complete privacy in casitas and the private swimming pools. Privacy is insured by the construction of the casitas, by carefully planted shrubbery and the Las Brisas Security Department.

An interesting, and unusual, feature of the hotel is that guests must sign a "no tip" pledge. Las Brisas operations more closely resemble a private club and any employee found accepting a tip is dismissed instantly.

The main dining room of the hotel overlooks Acapulco Bay and takes its name from the "beautiful view" *bella vista*.

Special features during the January 15th-21st Acapulco Winter Meeting include an Acapulco Bay cruise and, as an optional extra, a



jaunt on the Las Brisas Group Safari. Each Sunday afternoon the hotel sponsors a safari where each couple drives their own jeep through fishing villages, to a coconut plantation. At the plantation a cockfight is arranged and natives climb palm trees and cut coconuts for the guests. Small motor boats are used for taking the members of the safari up to the "Tres Palos" Lagoon Channels. Then the jeeps continue to the "Playa Encantada" Beach Club for a swim and the famous Las Brisas burro races and a bar-b-que feast.

At all times during the Acapulco Winter Meeting there will be an experienced tour conductor to assist the physicians and their families. □

### **Medical-Legal Institute Set For Fountainhead Lodge - July 18th-20th**

The bi-annual medical-legal institute of the OSMA and the Oklahoma Bar Association has been scheduled for July 18th-20th at Fountainhead Lodge on Lake Eufaula.

In keeping with the policy of the joint committee in the past, there will be a registration fee of \$40 per physician or attorney. The joint committee feels that the program should be entirely self-supporting.

HEW's report on malpractice will be the subject of the first session on Friday morning, July 19th. This monumental report took nearly two years to compile and write and ends up with a series of recommendations that will help alleviate the malpractice situation for physicians.

A representative of the HEW committee that compiled the report will be present to discuss it in depth with physicians and attorneys.

Immediately after the lunch break on Friday afternoon, there will be a discussion of recent developments in workmen's compensation law as it affects physicians. This discussion will be conducted by Judge Thomas Guggle, Jr., of the Oklahoma Industrial Court.

Starting at 3:00 p.m. on Friday there will be a discussion of professional standards review organizations of interest to both physicians and attorneys. Don Blair, Executive Director of the OSMA, will present an explanation of the PSRO law and an overview as to how it will affect the practice of medicine.

Don Wilson of the AMA's legal office in Chicago will discuss the legal ramifications and possible malpractice pitfalls to be found in the PSRO law. He will cover such topics as the confidentiality of patient records, whether the "norms of care" could become community standards of care, and the liability of physicians serving on the PSRO itself.

Saturday morning will be devoted to federal legislation. At least three members of the Oklahoma Congressional Delegation have agreed to discuss various pieces of currently pending federal legislation. The three members include Senator Henry Bellmon, Senator Dewey Bartlett and Congressman Jim Jones. Each of them will be asked to give their personal feelings on national health insurance and no-fault automobile insurance. In addition, each will then be given an opportunity to discuss whatever pending federal legislation he feels would be of interest to the group.

"What to do when the IRS comes" will be the subject of a special one-hour presentation by Mr. Richard F. McDivot, a partner in the law firm of Felix, Bohlman, McIntyre and McDivot. He is a former internal revenue service agent and is considered an expert on the subject, the care and handling of the IRS.

The last presentation of the day will take place during a special luncheon for all physicians, attorneys and their families. The guest speaker will be Frosty Troy, the controversial editor of the *Oklahoma Observer*. His caustic remarks and barbed comments miss very few Oklahoma politicians. At the same time, he calls on 25 years of political reporting to give an insight into Oklahoma politics that is extremely revealing.

The remainder of the weekend at Fountainhead will be open for recreation and relaxation.

There will be an Early Bird cocktail party Thursday evening, July 18th, and the second cocktail party on Friday afternoon, July 19th. The noon luncheon on Saturday is the only meal function.

As in the past, the committee has avoided having an evening meal function in order to give those persons attending the institute an opportunity to go to Krebs, Oklahoma, and visit one of the many fine Italian restaurants.

Persons wishing to attend the institute should write the OSMA office in Oklahoma City. □



## DEATHS

FORREST S. ETTER, MD  
1893-1974

Forrest S. Etter, MD, 81, Bartlesville physician, died April 21st, 1974. Born in Eldon, Missouri, Doctor Etter received his medical degree from St. Louis University School of Medicine in 1920. His original practice was established in Beggs, Oklahoma before moving to Bartlesville in 1926, where he maintained his practice until the time of his death. In 1971, the OSMA honored Doctor Etter with a Fifty-Year Club Membership for over a half century of dedicated service to humanity.

FRED B. HICKS, MD  
1884-1974

A long-time Oklahoma City physician, Fred B. Hicks, MD, died April 14th, 1974 in Oklahoma City. A native of Bellenfontaine, Mississippi, Doctor Hicks was graduated from the University of Tennessee College of Medicine in 1911. He specialized in otolaryngology. For the outstanding service he rendered

to humanity and the medical profession, he was awarded an Honorary-Life Membership in the OSMA in 1958.

PHILIP F. HEROD, MD  
1883-1974

El Reno ophthalmologist Philip F. Herod, MD, died May 25th, 1974. Doctor Herod was a graduate of the University Medical College of Kansas City and had practiced in El Reno for many years. In 1958 the OSMA presented him a Fifty Year Club membership for his many years of outstanding service in medicine.

JAMES R. HUGGINS, MD  
1904-1974

A long-time Oklahoma City physician, James R. Huggins, MD, died May 7th, 1974. A native of Chickasha, Oklahoma, Doctor Huggins moved to Oklahoma City in 1908 and graduated from the University of Oklahoma College of Medicine in 1933. He was a member of the American Academy of Family Physicians. □

## Book Reviews

**PEDIATRIC OTOLARYNGOLOGY**, Vol. 2, Edition 2, of the Respiratory Tract in Children, edited by Charles F. Ferguson, MD, and Edwin L. Kendrick, Jr., MD, Philadelphia, pp. 819-1369. W. B. Saunders, 1972. \$25.00

The book is the second volume of a two volume set. The first concerned the lower respiratory tract and this edition is devoted to pediatric otolaryngology. The book is designed to appeal to clinicians seeing children rather than as a definitive text on pediatric otolaryngology.

The book is divided into sections and each section begins with an appropriate description of the embryology and anatomy of the body regions. This is usually followed by description of the methods of examination, clinical and therapeutic aspects. In most instances, the illustrations are of good quality.

The chapter on inner and middle ear disease are particularly well done. Some of the others

will perhaps be repetitious for the otolaryngologists.

All in all the book will be a valuable addition for physicians who treat diseases in children.  
*Harris D. Riley, Jr., MD*

**HYDROCEPHALUS AND THE CEREBROSPINAL FLUID**. By Thomas H. Milhorat, 237 pp. Williams & Wilkins Company, Baltimore, 1972. \$18.50.

This monograph brings together in an effective fashion information concerning basic physiology, clinical features, as well as investigative contributions to the subject of hydrocephalus. The book is divided into six chapters: cerebrospinal fluid physiology, pathogenesis of hydrocephalus, pathology of hydrocephalus, pathophysiology of hydrocephalus, diagnosis of hydrocephalus and treatment of hydrocephalus. Each chapter is well written and well illustrated with radiographs, pathologic specimens and tables.



## Book Reviews

As the author states in the preface, some of his personal bias has been interjected. The difficulty in outlining a satisfactory classification of hydrocephalus is noted. The author divides hydrocephalus into two broad categories: communicating and non-communicating and the causes of each are listed. There is obvious duplication by this classification.

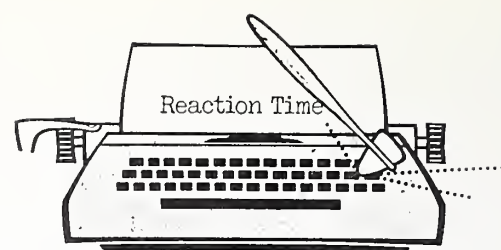
The monograph is intended primarily for clinicians interested in the problem of hydrocephalus. *Harris D. Riley, Jr., MD*

**THE FUTURE OF MEDICAL EDUCATION.** By William G. Anlyan, *et al*, 192 pp. Duke University Press, Durham, No. Carolina, 1973. \$8.50.

This is an informative, well organized and concise monograph which deals with the immediate future rather than long-term projections of medical education. The authors are all involved in medical education and are in a position to construct their view of the future on a factual appreciation of what has gone on in the past and is currently in progress. They set out to predict the course that medical education should take now in order to prepare physicians for the practice of medicine, a decade and more from now. Individual chapters deal with the practice of medicine in 1985, sources and admission of students and various aspects of medical education including the constantly changing relationships between medical schools and the general university. Each of the 12 topics is reviewed in a separate chapter prepared by one or two of the authors.

The book will be valuable reading for those who should know about the priorities of medical educators and what medical schools are attempting to accomplish. Another important point which is emphasized which in many respects is counter to some of the present discussions about medical education is the need to maintain rigorous standards of medical education. Perhaps if there is any defect of this book it is the relatively sparse mention of financial considerations which are so all important.

This is an exceedingly worthwhile book covering the important aspects of medical education. It is to be recommended. *Harris D. Riley, Jr., MD* □



March 4, 1974

Honorable Henry Bellmon  
United States Senate  
Washington, D.C. 20510

Dear Senator Bellmon:

I am writing to thank you for your letter of February 26. As chairman of the legislative committee of the Oklahoma State Medical Association concerned primarily with State legislation, we often hear the justified criticism of our State representatives and senators that we seldom thank them for doing anything right. We usually let them know when we are opposed to something, but aren't considerate enough to thank them when they have done something well or been of service.

We are, I am certain, guilty of this. I can't help but think that many other objectionable things that have happened that adversely affect medical care and increase federal costs could have been prevented if more doctors as individuals would raise the hue and cry that they did over this most recent proposal. However, they don't and it is my opinion that in many instances, we are our own worst enemy.

Thank you very much for the effort you expended in our behalf. The objections that physicians and organized medicine do raise to some of these federal regulations and programs are not based on fear of loss of income or of anything happening to us personally. We simply are in a position to know more about what is going to happen and how it will be abused than the people are who in most instances formulate the rules and regulations and programs to which we so often object. . . . The State Medical Association has never asked our legislature or the congress for anything that would line the pockets of a doctor with a single buck. It is becoming increasingly unpleasant to practice medicine. Doctors aren't lily white. I don't think

Medicare has been all bad. I do think it would be profitable for those in power to listen to us more often.

Again, I want to thank you very much for your efforts in our behalf recently.

Sincerely,  
R. B. Carl, MD

RBC/cf

March 29, 1974

R. B. Carl, MD  
826 Northwest 11th Street  
Oklahoma City, Oklahoma 73106

Dear Dr. Carl:

You are right in saying that we are seldom thanked for doing anything right, but heavy on criticism when it appears we have taken the wrong course of action. However, let me assure you that this is part of the game and soon comes to be expected. I have found that those who are content with life are more prone not to write, but those who face many frustrations become quite prolific at times. I welcome both.

Your kind words of appreciation were very gratifying. Apparently the objections you and others raised has had the desired impact. We will attempt to keep on top of this matter until it is finally resolved.

You might also be interested in knowing that on March 21 I introduced S 3214 to repeal that section of PL 92-603 which authorizes PSRO's. The average citizen, in my opinion, would much prefer being treated by a physician exercising his own medical judgment rather than one following arbitrary guidelines approved by the federal government.

Your recommendations and advisement are always welcome. It is only in this way that we can convey your concern, and as you can see it pays off in the long run. Thanks again for your kindness. Best wishes.

Sincerely,  
Henry Bellmon

HB:sab

□

## Miscellaneous Advertisements

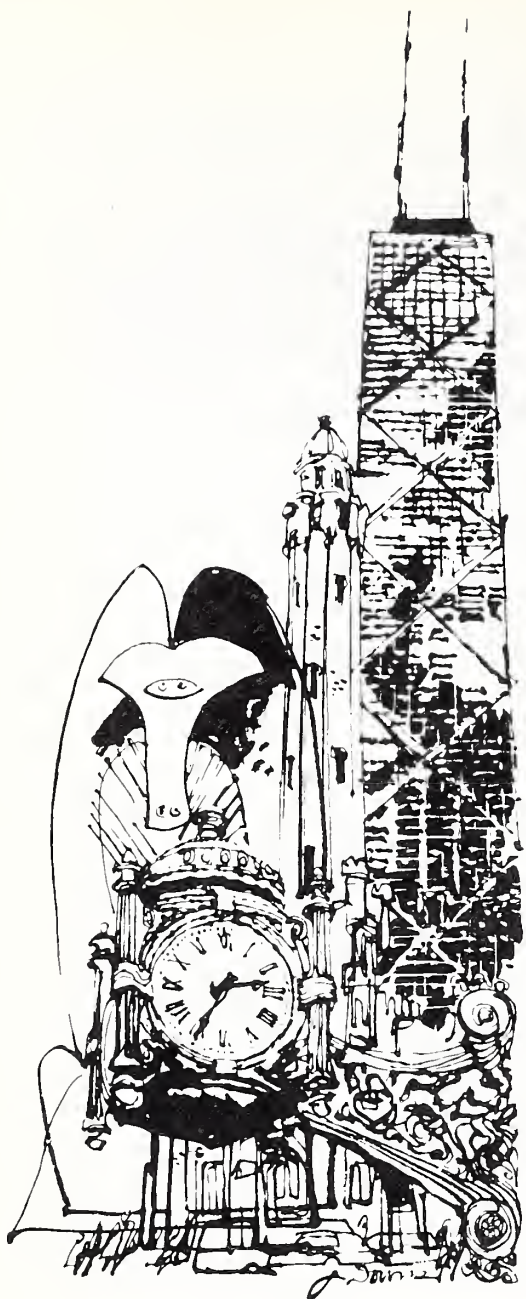
MOVE TO GREEN COUNTRY . . . away from big-city pressures. City of 1,000 with industry and 8,000 surrounding population desires one or, preferable, two GP's. Medical Center with complete equipment and medical records available for lease or purchase. Financing available. Former physician's name and phone number available on request. Thirty miles from Lake Tenkiller and 50 miles from Beaver Lake, Arkansas. For further details, phone collect, Rodney Opitz, 918 723-5466 or Jim Talbot 918 723-5453, Westville, Oklahoma 74965.

LAWTON, OKLAHOMA medical office for lease. GP Specialist. Immediate occupancy. Six room suite; two examining rooms, one conference; 750 square feet; panel walls, carpet; \$300 per month; laboratory; x-ray; parking. Five minutes to hospital; 24-hour coverage; 100,000 population. Excellent schools, churches, friends. Physicians needed. Contact W. J. Atkinson, MD, 605 West Gore Boulevard, Lawton, Oklahoma 73501.

A BETTER PLACE to practice medicine. Enjoy practicing medicine in a warm climate, and with the friendly people in Wichita Falls, Texas. Our brand new 55,000 square foot clinic building has new offices and examining rooms ready for specialists in Internal Medicine, Family Practice and Diagnostic Radiology. We are a multi-specialty group located in a city of 100,000 people in North Central Texas—close to everything—but away from big city problems. Call collect, Dr. Preston McCall at 817 766-3551, at 501 Midwestern Parkway, East, Wichita Falls, Texas 76302.

FOR SALE: Office furniture and equipment. Consists of three Leopold walnut desks and chairs. One walnut examining table. Diagnostic x-ray and fluoroscope, diathermy, ultra violet light, pressure sterilizer and one hot water sterilizer. Several pieces of laboratory equipment. Very good furniture in waiting room. Contact F. M. Duffy, MD, 211 W. Maple Street, Enid, Oklahoma 73701. Phone 405 237-5800. □





# 123rd

## AMA ANNUAL CONVENTION JUNE 22-26, 1974 CHICAGO, McCORMICK PLACE

- *Scientific Sessions* including Hypertension/Management of Obesity/A Practitioner's Approach to Angina—1974
- *Postgraduate Courses* including Cardiopulmonary Resuscitation/Total Parenteral Nutrition/Workshop on Human Sexuality/American Society of Clinical Pathologists: special courses for non-pathologists
- *Fireside Forums*—return of a popular evening session in a new "meet the professor" format
- *Scientific Exhibits* including Clinical Pathologic Conferences/Live Teaching Clinic/Fresh Tissue Pathology
- *Film Symposia* including a ½-day session on techniques of producing a medical motion picture in your hospital
- *Charter flights* are being planned from Los Angeles, San Francisco and Dallas.

Write a letter with the coupon below to the AMA or see the JAMA Convention Issue on April 15, 1974, for scientific session lists, hotel reservations, and course registrations—as well as social activities while in Chicago this June.

### Advance Registration

**123rd AMA Annual Convention  
June 22-26, 1974  
Chicago/McCormick Place**

Please return this form before May 24, 1974, to:  
Circulation and Records Department  
American Medical Association  
535 North Dearborn Street  
Chicago, Illinois 60610

Please print

Name \_\_\_\_\_  
(each physician must register in his own name)

Office Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

I am a member of the AMA through the following State Medical Association or government service \_\_\_\_\_

**Please send more information on the charter flights being planned from:**

—Los Angeles —San Francisco —Dallas

In accordance with the AMA Bylaws, I hold active membership in the AMA, and I wish to vote in the Scientific Sessions. I have checked:

- |  |  |
|--|--|
| 01 <input type="checkbox"/> Allergy                                | 13 <input type="checkbox"/> Obstetrics and Gynecology            |
| 02 <input type="checkbox"/> Anesthesiology                         | 14 <input type="checkbox"/> Ophthalmology                        |
| 26 <input type="checkbox"/> Cardiovascular Diseases                | 15 <input type="checkbox"/> Orthopedic Surgery                   |
| 05 <input type="checkbox"/> Clinical Pharmacology and Therapeutics | 10 <input type="checkbox"/> Otorhinolaryngology                  |
| 20 <input type="checkbox"/> Colon and Rectal Surgery               | 16 <input type="checkbox"/> Pathology                            |
| 03 <input type="checkbox"/> Dermatology                            | 17 <input type="checkbox"/> Pediatrics                           |
| 04 <input type="checkbox"/> Diseases of the Chest                  | 18 <input type="checkbox"/> Physical Medicine and Rehabilitation |
| 07 <input type="checkbox"/> Family and General Practice            | 27 <input type="checkbox"/> Plastic and Reconstructive Surgery   |
| 11 <input type="checkbox"/> Federal and Military Medicine          | 19 <input type="checkbox"/> Preventive Medicine                  |
| 06 <input type="checkbox"/> Gastroenterology                       | 12 <input type="checkbox"/> Psychiatry                           |
| 08 <input type="checkbox"/> General Surgery                        | 21 <input type="checkbox"/> Radiology                            |
| 09 <input type="checkbox"/> Internal Medicine                      | 22 <input type="checkbox"/> Urology                              |
| 24 <input type="checkbox"/> Neurological Surgery                   |  |
| 25 <input type="checkbox"/> Neurology                              |  |

### General Registration

- AMA members and their guests: no fee  
—Non-member physicians: \$25  
—Guests of non-members: \$5  
—Medical students, interns and residents: no fee

My remittance of \$\_\_\_\_\_ is enclosed.  
(Make check payable to American Medical Association.)  
Check must accompany registration.



**C. RILEY STRONG, MD**  
**1920-1974**

Doctor C. Riley Strong of El Reno died at home on June 10th, less than a month after completing his term as President of the Oklahoma State Medical Association. We shall miss Riley.

He was not only a big man physically, but to those who knew him well he loomed even larger in the stature of his character.

Riley was simple and direct in dealing with people or problems . . . in all matters he wanted to do the right thing . . . he sought and valued advice . . . his credo was fairplay . . . if he erred it was always unintentional and never from neglect or malice . . . he could admit a wrong quickly and easily, and would apologize to the world if he felt guilty of even the slightest oversight . . . the problems or achievements of others became his burdens or his joys . . . he was an exceedingly happy man who was always fun to be around . . . good-natured Riley loved laughter, even at his expense if others took pleasure from it.

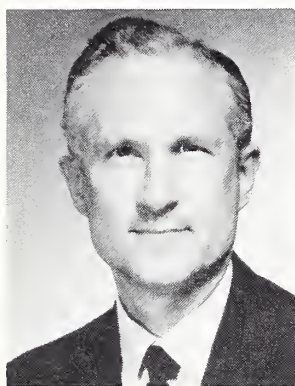
No one we have ever known could have exceeded his capacities for love and loyalty. He was absolutely genuine in his love for others, and he treasured those who extended friendship or love to him. Riley never wanted for friends . . . he acquired them instantly and preserved them forever.

In an era of mixed up priorities, Riley's basic qualities persevered where those of more complex individuals have failed. The consistent apex of his life was his family . . . all other priorities were arranged in descending order from that point.

He was a devoted doctor, too . . . and a leader in medicine . . . and an all-around solid citizen.

But, most importantly, he was plainly and simply a good and bighearted man whose passing saddens us immensely. — *Don Blair*



**A BLACK DAY AT THE AMA**

I predict that June 26th, 1974, will, from that day henceforth, be recorded as a day of tragedy in the annals of the American Medical Association. I sat stunned as the soft underbelly of a potentially great institution became exposed, causing many of us to be not only surprised, but embarrassed. To me it is almost unreal — a night-

mare from which I would hope we could all awaken. But *it is* very real and a malady from which I do not expect a satisfactory recovery.

I refer, of course, to the debacle in Chicago of PSRO as handled by the House of Delegates. Since I do not expect our national membership ever to be advised by the AMA as to the actual events that did transpire, I herewith respectfully submit to you my observations.

After the initial meeting of the House of Delegates on Sunday, various matters of business were allocated to reference committees "A through H" with "A" having the consideration of PSRO as its assignment for a hearing on Monday. By Tuesday evening, all reference committees had completed their reports, with the single exception of "A," and had met their commitments necessary for floor debate. It was not until Wednesday morning, some 36 hours following their committee meeting, that their delayed report was given to the delegates — one day before the end of the entire meeting. Reference committee "A," in its unduly delayed report, had the arrogance and audacity to admit that it had *not* been influenced in its decisions by the volume of debate provided against PSRO, but had arrived at its recommendations to support PSRO through *its own* judgment! This is democracy at work? Why have discussion or debate? Or why have a reference committee at all, if this is to be the procedure?

When the subject of PSRO was finally initiated in the House of Delegates, a very peculiar thing happened. Immediately and with apparent preplanning, a pro PSRO enthusiast from Wisconsin arose and made a motion that debate should be stopped and the matter of repeal submitted to a vote forthwith. This motion to stop debate was responded to with some

enthusiasm by the Speaker of the House and was passed without any appreciable dissent by the overwhelming majority of 202 to 24! In retrospect, one can only assume that both opponents and proponents of repeal felt secure in the strength of their respective positions and were not eager to see a four or five hour debate ensue. Then the blockbuster occurred. When the vote to repeal PSRO was taken, it failed by the margin of 184 to 57. Your Oklahoma delegation could do no more than respond with stunned disbelief. What had happened to all those claiming a stand of firm opposition to PSRO, to those who had given us in Oklahoma both oral and written promises of fighting a battle to the bitter end to protect the public and the medical profession? Obviously there had been a copout. But what could induce learned men, presented with all the good facts about private enterprise and all the faults of government intervention, to so dispense with their logic and previous moral commitments? Your three delegates from Oklahoma never waived from their stand nor had they been approached by the PSRO enthusiasts to alter their position — apparently just about the only state not courted to do so. Obviously, the opposing forces knew our delegates could not be influenced.

So what did happen? Obviously the opposition did its homework well. What trade-off effected the changes in otherwise thoughtful and dependable men? One can only conjecture. Perhaps the numerous Federal grants of large sums of money already allotted for planning programs had their influence. Certainly the well-known supporters of PSRO had done their work efficiently and convincingly and at the end of the meeting appeared happy — even ebullient. What they think they have gained remains a mystery to me. The medical profession has now been removed from any bargaining position at all. It is my opinion that we are in a weaker position to gain any modifications or changes in an unwise and unfair set of laws. The government bureaucrats must now realize that they have intimidated us quite successfully and can do as they will. Who now can stop them from instituting a set of restrictions and progressively increase those restrictions? History has proved that what government obtains it does not release. We shall soon see that the private practice of medicine will never again in our lifetimes be the great profession as we have known it and, more importantly and more tragically, the public — our patients, will be even greater losers.

In reflection, the proponents of PSRO have played a very contrived, effective delaying game and have succeeded. I see no good chance of any reversal of this unfortunate occurrence. We now must work harder than ever to see that the harm done our patients by it is minimized. A law has been supported that will cost this nation \$100,000,000,000 a year (PSRO plus NHI), \$500,000,000 of which could be for administrative costs alone. It is not a thing to be proud of. The AMA will rue the day of June 26th, 1974.

*J. L. Richardson, M.D.*  
J. L. Richardson, MD

# Polyarthrititis After Small-Bowel Bypass

RICHARD J. HESS, MD

*Symmetrical polyarthrititis resembling rheumatoid arthritis occurs in some patients having small-bowel bypass surgery for treatment of obesity. This complication may be related to other arthropathies associated with intestinal disease.*

The musculoskeletal manifestations that occur in obese patients who have had an intestinal bypass procedure for obesity have been reported.<sup>1, 2</sup> In a few patients symptoms were moderately severe, lasted over 24 months and resembled rheumatoid arthritis. Reported here are two additional patients with prolonged, symmetrical synovitis resembling rheumatoid arthritis which followed jejunocolostomy for obesity.

## CASE REPORTS

### Case 1:

L. L., a 33-year-old woman, weighed in excess of 350 lbs prior to the performance of a jejunocolostomy in August, 1968. When first examined for arthritis on November 19, 1971, she weighed 144 lbs representing at least a 210 lb weight loss. She did well until January, 1971 when pain and stiffness occurred in both shoulders.

Subsequently, stiffness, swelling and pain progressively involved the small joints of her hands, her feet, wrists, elbows, knees, and ankles. Morning stiffness was prominent and severe, lasting two hours. No unusual fatigability existed.

Examination revealed a well-developed and well-nourished woman: height 64 inches, weight 144 lbs, blood pressure 118/70, pulse 76/min. Pertinent physical findings included fusiform synovial thickening of the proximal interphalangeal joints, metacarpophalangeal joints and the wrists. The elbows could be extended to only 175°. There were bilateral bulge signs at the knees. No subcutaneous nodules were present and there were no cutaneous manifestations of vasculitis. The remaining peripheral and axial joints were normal.

The laboratory results at the time of initial evaluation were as follows:

Hemoglobin 13.4 gm %, hematocrit 40%, white blood cell count 7,600/cu mm with a normal differential; Westgren sedimentation rate 11 mm/hr; urinalysis negative; serum urea nitrogen 9.4 mg %, uric acid 5.9 mg %, ASO titer 100 Todd units; latex fixation test negative; LE preparation negative; VDRL nonreactive; fasting blood sugar 46 mg %; 2 hr post-Glucola blood sugar 65 mg %.

Roentgenograms of the hands and wrists showed soft tissue swelling about the proximal interphalangeal joints, metacarpophalangeal joints and adjacent to the ulnar styloids at the



## *Polyarthrititis* / HESS

wrists. No joint space narrowing, erosive changes or periarticular osteoporosis was apparent. The sacroiliac joints appeared normal.

Treatment was initiated with salicylates and physiotherapy. After two months, no significant improvement was noted and antimalarials were added to the therapeutic regime. Six weeks later her morning stiffness and other systemic symptoms had greatly improved and the synovial thickening of her hands and wrists was less apparent. In July, 1972 she developed an acute tenosynovitis along the lateral aspect of the left wrist. Local injection of a corticosteroid prompted quick resolution.

As of December, 1973 she continues to do well. She has persistent low grade synovitis of the proximal interphalangeal joints and metacarpophalangeal joints of the hands and wrists. The hemogram and Westgren sedimentation rate remained normal and the test for rheumatoid factor is negative.

### Case 2:

R. C., a 29-year-old woman, had a jejunocolostomy for treatment of obesity in September, 1967. Subsequently she lost weight from 298 lbs to 165 lbs. In November, 1970 she experienced swelling, pain and stiffness of the proximal interphalangeal joints, metacarpophalangeal joints, wrists, and ankle joints. Morning stiffness was severe and lasted three hours. Mild fatigability was noted after six hours of normal activity. She was initially evaluated for arthritis in February, 1972.

Examination revealed: height 66 inches, weight 165 lbs, blood pressure 110/80 and pulse 88/min. Pertinent physical findings included synovial thickening of the proximal interphalangeal joints and metacarpophalangeal joints of the hands and synovial thickening of both wrists. The ankles were effused and the synovium was thickened.

Laboratory data were as follows:

Hemoglobin 14 gm %; hematocrit 44%; white blood cell count 6,500/cu mm with a normal differential; Westgren sedimentation rate 14 mm/hr; urinalysis negative; ASO titer 150 Todd units; latex fixation test negative; LE preparation negative; serum urea nitrogen 12.6 mg %; uric acid 5.5 mg %; VDRL nonreactive; 2-hr post-Glucola blood sugar, 100 mg %.

Roentgenograms of the hands and wrists demonstrated soft tissue swelling about the proximal interphalangeal joints and the metacarpophalangeal joints. The wrists were normal

except for soft tissue swelling adjacent to the ulnar and radial styloid processes. The ankles were normal except for periarticular soft tissue swelling. The sacroiliac joints appeared normal.

The patient was treated with salicylates and physiotherapy. A gratifying response occurred after two months of treatment. Systemic symptoms subsided. Synovial swelling persisted. In July, 1972 she experienced an exacerbation of her systemic symptoms. A parenteral injection of corticosteroids provided symptomatic relief; however, the patient was given indomethacin 25 mg tid. She has done well except for a couple of days each month of increasing joint stiffness and some fatigability. In October, 1973 she continued to have low-grade synovitis of the proximal interphalangeal joints and metacarpophalangeal joints of the hands, wrists and ankles. The hemogram and Westgren sedimentation rate have remained normal and her rheumatoid factor is negative.

### DISCUSSION

Shagrin, Frame and Duncan<sup>1</sup> noted that seven out of 31 patients (23%) who had intestinal shunts for the control of obesity developed articular symptoms. All seven patients had undergone jejunocolostomy. None of the patients having a jejunoileostomy developed arthritis. In two patients the symptoms lasted over a period of three years and consisted of symmetrical polyarthrititis that closely resembled rheumatoid arthritis. In both these cases tests for rheumatoid factor, antinuclear factor and LE preparations were negative. In one patient the Westgren sedimentation rate was normal; it was not reported in others.

A recent report by Buchanan and Willkens<sup>2</sup> has linked jejunoileostomy to the subsequent development of acute polyarthrititis. Also, recurrent arthralgia in ten of 150 patients with jejunoileostomies has been noted.<sup>2</sup>

*A 1963 graduate of Temple University School of Medicine, Richard J. Hess, MD, limits his practice to his specialty of rheumatology and internal medicine. He is certified by the American Board of Internal Medicine and is presently Clinical Instructor in the Rheumatology Section of the Department of Medicine at the University of Oklahoma Health Sciences Center. His medical affiliations include the American College of Physicians, the American Rheumatism Association, the American Society of Internal Medicine and the Royal Society of Medicine.*



In two patients reported in this study, jejunocolostomies had been performed and significant weight loss followed. The arthropathy in each was characterized by symmetrical synovitis of the proximal interphalangeal joints and metacarpophalangeal joints of the hands and wrist joints. Also the knees and ankles were intermittently swollen and painful. Morning stiffness that lasted longer than one hour was quite prominent. Interestingly each patient had considerable fibrositic and myositic symptoms that suggested a diffuse rheumatoid diathesis. In neither was the sedimentation rate elevated, nor was the test for rheumatoid factor or LE cells positive. Rheumatic symptoms began three years and three months after surgery in one patient and three years and two months after surgery in the second.

That these findings are coincidental is a possibility; however, these recent cases came from a practice limited mainly to rheumatology and no large number of patients who had undergone ileal bypass were available. This suggests that the syndrome of rheumatoid-like disease following intestinal bypass surgery is a distinct entity. Similar conclusions have been made previously.<sup>1, 2</sup>

Also, it is not surprising to discover an arthropathy associated with an anatomic interception of the intestinal tract, since so many primary diseases of the gastrointestinal tract are also associated with arthritis. The pathophysiology of arthritis that occurs in association with enteric disease is unknown. The intestinal diseases often associated with arthropathy include ulcerative colitis, granulomatous colitis, regional enteritis, Whipple's disease, Behcet's syndrome, and some infections of the intestine such as salmonellosis, shigellosis and brucellosis.<sup>1</sup>

Other nonsurgical complications of ileal bypass surgery include orthostatic hypo-

tension, gastric ulcer, tetany, renal lithiasis, dehydration and electrolyte imbalance, specific deficiencies of vitamin A, vitamin C and magnesium, hepatic failure, and death.<sup>1, 3, 4</sup>

Hepatic dysfunction and malabsorption of fats and electrolytes have been the most prominent complications of both jejunocolostomy and end-to-end jejunoleostomy.<sup>2</sup> Liver biopsies following bypass surgery have been followed, variously, by massive fatty changes, cholestasis, polynuclear inflammatory infiltrates, diffuse fibrosis, bile duct proliferation, and fatal hepatic necrosis.<sup>3</sup> Massive hepatic steatosis has been reported mainly with jejunocolostomy; however, a recent study has also shown jejunoleal bypass to produce a three-fold increase in excess hepatic lipid, as triglyceride, normally present in the obese.<sup>5</sup>

Now in addition to these problems, a rheumatoid-like arthropathy occurs with both types of bypass surgery. This polyarthritis is most similar to the arthropathy of Whipple's disease.<sup>6</sup> Maybe in bypass surgery, the large blind-loop functions in a manner like that in other forms of bowel disease and the role of intestinal stasis, malabsorption and bile salt metabolism might prove to be important in the pathogenesis of all enteric arthropathies.<sup>2</sup> □

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## News From The Oklahoma State Department of Health

### RABIES HYPERIMMUNE SERUM

Hyperimmune serum has proved effective in preventing rabies. Its use in combination with vaccine is considered the *best* post-exposure prophylaxis. Unfortunately, the only preparation of antirabies serum commercially available in the United States is of equine origin.

The administration of equine serum should be carried out by a qualified physician, and only after appropriate tests for hypersensitivity have been performed. These are risks involved in the use of equine serum — *however, there are also risks involved in less than optimal antirabies prophylaxis.*

The recommended dose of antirabies serum is 40 IU (1 vial)/55 pounds. Up to 50 percent of the antiserum should be used to infiltrate the wound and the rest given intramuscularly.

In persons hypersensitive to equine sera, a decision must be made to give, or not to give, antirabies serum. Hypersensitivity is determined by the intradermal injection of 0.1 ml of a 1:1000 dilution of antirabies serum in normal saline. The test is read in 20 minutes and is positive if a wheal 1 centimeter or more in diameter is present.

Desensitization and serum administration are recommended in rabid bites and in all bite exposures where rabies cannot be ruled out in the biting animal (e.g. when biting animal has escaped, or in all bites by wild animals). When serum is to be used in hypersensitive persons it should be given in gradually increasing doses. See dosage schedule in Reference 2.

In the event of a reaction during the course of therapy in a hypersensitive patient, the subsequent doses should be reduced. Signs of acute anaphylaxis call for the immediate intravenous injection of 0.2 to 0.5 ml of 1:1000 epinephrine solution. □

### REFERENCES

1. Recommendations of PHS Advisory Committee on Immunization Practices.
2. Infectious Diseases of Children and Adults, Fifth Edition, Krugman & Ward.
3. Manual of Medical Therapeutics, Nineteenth Edition.

### COMMUNICABLE DISEASES IN OKLAHOMA FOR MAY, 1974

DISEASE	May 1974	May 1973	April 1974	Total To Date	
				1974	1973
Amebiasis	1	—	2	7	13
Brucellosis	—	—	—	2	2
Chickenpox	167	203	114	695	1142
Encephalitis, Infectious	2	3	4	15	8
Gonorrhea (Use Form ODH-228)	1019	1050	891	4310	4501
Hepatitis, A, B, Unspecified	98	110	81	487	465
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	1	1
Meningococcal Infections	—	3	4	11	10
Meningitis, Aseptic	6	5	5	20	20
Mumps	52	51	48	308	296
Rabies in Animals	14	27	21	64	97
Rheumatic Fever	4	2	—	7	9
Rocky Mountain Spotted Fever	7	13	3	10	17
Rubella	6	27	4	29	159
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	6	18	2	19	40
Salmonellosis	45	20	23	107	75
Shigellosis	15	18	12	56	88
Syphilis, Infectious (Use Form ODH-228)	13	12	12	70	85
Tetanus	—	—	—	—	1
Tuberculosis, New active	24	23	31	119	128
Tularemia	1	—	—	3	7
Typhoid Fever	—	—	—	—	1
Whooping Cough	1	4	—	6	14

# Inauguration Address

*Presented by Jack L. Richardson, MD, Tulsa, on May 14th, 1974, in Oklahoma City.*

One should be very proud to be elected to an office in the Oklahoma State Medical Association. Proud of the personal and professional relations it will provide him, proud of the high ethical and moral standards of its membership and very proud of the great organizational staff that has been developed in its executive headquarters. I do not believe it to be excelled by any other state association of similar size. There is much to be accomplished and much that will be accomplished by combined effort. There are many challenges being presented to us and mature judgment will be required. Never has the need for unity been more clear. Never has it become more evident that each physician must contribute to organizational matters and not confine himself alone to the treatment of patients. At one time it was sufficient to treat the ill, but to confine oneself to this alone will be to default to those who are attempting to interfere with the proper practice of our profession.

I find it sad that so much of our time has been necessarily diverted from primary medical interests in order to protect the public and our profession from the intrusion by our own federal government. Since the welfare of our patients has always been our greatest concern, we cannot countenance anything that would diminish that welfare. It is utterly ridiculous that the government would contend, and that the public would assume, that the government could or would provide better medical care than has already been provided by the greatest, most advanced, most progressive medical community the world has ever known. Washington's demand that we prove to them our efficiency in cost control would be a source of considerable humor, if its possible results might not be so tragic. This demand is made by a political body that has been profligate with its spending and grossly inefficient in its procedures. There are several questions that I think should be raised in the minds of the public again and again. Who is it that has spent us into the greatest national

debt in the history of the world? Who is it that has lost the peace after every war that our military has been allowed to win? Who is it that has loaned untold billions indiscriminately around the world without any product, repayment, friend or ally resulting? Who was it that changed old ghettos into tremendous high-rise ghettos that had to be abandoned because of poor planning, poor construction and poor management? Who was it that just a month ago exhibited the brilliant statesmanship of handling one debt owed to us by India by reducing it from three billion dollars to one billion dollars and then agreed that the one billion be spent in India? All this while forgiving and forgetting at the same time that that country has been antagonistic and critical of us for many years. Who is it about to legislate us into a second rate world power by the attitude toward military preparedness and a no-win policy in war? Who is it at fault for the fuel crisis? Who is it at fault for the delay in the Alaskan pipeline? These are the questions we and the public should be asking each other and our government. Yet our legislators have the temerity to challenge our interest and efficiency in cost control! Never has any nation had better medical care. Never have so many received so much from so many for so little. When President Kennedy was in office and the first great interference of our profession was initiated, investigators were sent from border to border and coast to coast in an attempt to find persons who were urgently in need of medical care, but who could not obtain it. Remember that not a single such case could be documented. Now the Congress has members who have proposed a National Health Act costing eighty billion dollars a year or almost three times the annual cost of fighting the most expensive war in our history. Even Mr. Weinberger has just estimated that the President's plan would have a cost of sixty billion dollars a year and, as we all know, these estimates are invariably lower than actually prove to be the case. All these



## *Inauguration Address/RICHARDSON*

years, our motto has in effect always been "Think not what we can do for ourselves, but what we can do for our patients." How many politicians practice this same philosophy? Now then, can there be improvement in medical care? Yes, just as there can be in any other facet of our life. Should there be a striving for improvement? Of course. But it will come in the future, as it has in the past, within our profession and not from government ultimatum.

Not only will government involvement increase cost and decrease efficiency, but their plan to computerize dossiers on every aspect of everyone's personal background, information subject to passing through the hands and before the eyes of thousands of people, will place each one's future in jeopardy. The possible loss of this confidentiality can result in many hazards to all individuals, resulting from everything from blackmail, bribery, divorce, loss of insurance coverage to unlimited liability litigation.

I do not think the doctors of these great United States will readily knuckle under to government domination as did those in many other countries so well known to us. They know the best care can be provided only under a sys-

tem of free enterprise. At the same time, I want to caution against two things. First, that it is the welfare of the public that should remain foremost in our minds as we react to attempted takeover and, second, that great circumspection should be exercised with regards to the termination of price controls under Phase Four. There are detractors waiting in the wings eager to take advantage of any intemperate act.

Our leaders have attempted to cooperate with the government and discuss matters to a logical conclusion, but HEW has not held to previous commitments and has firmly resisted. They have defaulted on commitments before regulations have even been promulgated. We have in the past and will continue in the future to review our own members for quality care and cost control without the necessity for anyone else to do it. We shall continue to provide our patients with the best care possible. On the other hand, if, in spite of this, the government continues to harass and handicap our patients with regards to the medical care they need, I predict that the medical profession will resist with all the force it can muster. ☐

J. L. Richardson, MD

President

Oklahoma State Medical Association

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If the Oklahoma Medical Political Action Committee (OMPAC) is going to be adequately prepared to support candidates of your choice in 1974, your \$20 membership or \$100 sustaining membership contribution is crucial.

OMPAC is your voluntary, bi-partisan political action arm. Your dollars are used to support Oklahoma candidates for federal and state office. The more dollars OMPAC has to spend, the more legislators there will be who understand medicine's legislative concerns and who will listen to your views and those of your colleagues.

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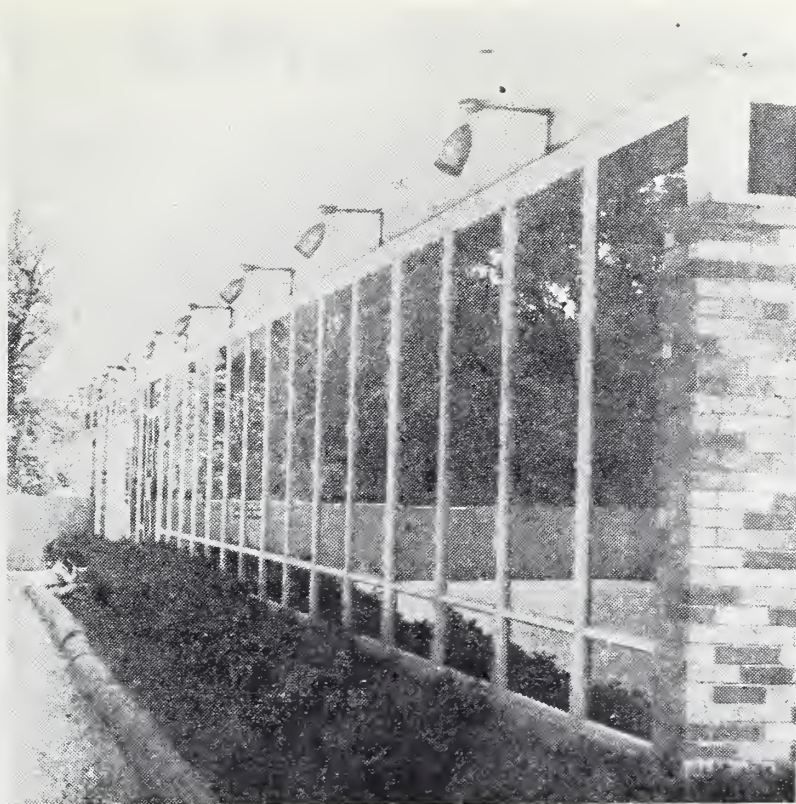
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**Upper lefthand corner:** Doctors Gerald Kethley and E. A. McGrew were just two of many persons who attended the oyster party during Oklahoma Medical Summit.

**Upper righthand and lower lefthand corners:** Over 100 scientific and technical exhibits drew interests from the nearly 4,000 persons that attended Medical Summit.

**Lower righthand corner:** Doctor Robert Bird, MD, Dean of the O.U. College of Medicine received a check for over \$16,000.00 from Doctor C. Riley Strong, OSMA President, for 1973-74. The money came through the AMA Education and Research Foundation.



# L SUMMIT



**Upper lefthand corner:** A new OSMA president-elect, Arnold Nelson, MD, left, discusses his new duties with the 1974-75 President of the OSMA, Jack L. Richardson, MD.

**Lower Lefthand corner:** Doctor Roth spent a great deal of time discussing modern medicine with OU medical students. The students were invited to a special "Meet the Presidents" forum to hear AMA President Roth and James Price, MD, President of the American Academy of Family Physicians.

**Upper righthand corner:** AMA President Russell Roth, MD, shown here being introduced by OSMA President C. Riley Strong, MD, had many occasions to speak during Oklahoma Medical Summit. He addressed the OSMA House of Delegates and a special luncheon during the meeting.

**Lower righthand corner:** New President of the OSMA Auxiliary, Mrs. Charlene Williams of Enid, received the traditional red roses to start her year in office. □



# Proceedings of 68th Annual Session of the House of Delegates of the Oklahoma State Medical Association

## OPENING SESSION

### I. CALL TO ORDER:

The House of Delegates convened its 68th Annual Session in the Skirvin Plaza Hotel, Oklahoma City, Oklahoma on May 12, 1974. The Speaker, Roger J. Reid, MD, Ardmore, called the meeting to order at 3:15 p.m.

### II. INVOCATION:

S. N. Stone, MD, Vice-Speaker, Oklahoma City, delivered the invocation.

### III. REPORT OF THE CREDENTIALS COMMITTEE:

The presence of a quorum was reported by Donald F. Mauritson, MD, Chairman, Tulsa.

### IV. PRESENTATIONS:

1. *Report of the President:* C. Riley Strong, MD.

Doctor C. Riley Strong, presented his report and it was referred to Reference Committee No. I (A copy of the report is attached and made a part of the minutes).

2. Presentation of AMA-ERF check to Robert M. Bird, MD, Dean, University of Oklahoma College of Medicine.

Doctor C. Riley Strong, OSMA President, introduced Doctor Robert Bird, Dean, University of Oklahoma Health Sciences Center, and presented him with an AMA-ERF check in the amount of \$16,834.30.

Doctor Bird reported briefly on the current affairs of the Health Sciences Center and its present dilemma, and expressed his thanks and appreciation for the privilege of attending the 1974 OSMA House of Delegates.

Doctor Reid introduced Betty Mahoney as the transcribing secretary.

### V. APPROVAL OF THE MINUTES:

The Speaker asked the pleasure of the House regarding the reading of the minutes of the last annual meeting.

*A motion was made that the minutes be approved as published in the Journal of the Oklahoma State Medical Association. The motion was seconded and it carried.*

### VI. REMARKS OF THE SPEAKER:

Doctor Reid reminded everyone to purchase their Gaslight Theatre tickets and luncheon tickets.

### VII. RECESS FOR CAUCUS OF TRUSTEE DISTRICTS:

Doctor Reid announced the House would recess for ten minutes for Trustee Districts VI, VII, VIII and IX to caucus.

### VIII. NOMINATIONS OF OFFICERS:

The House was declared open for the nominations for the position of *PRESIDENT-ELECT* (One year term of office).

Arnold G. Nelson, MD, Midwest City, was nominated by John Blaschke.

Nominations were declared closed.

Nominations were declared open for the position of *VICE-PRESIDENT* (One year term of office).

Roger J. Reid, MD, Ardmore, was nominated by Orange Welborn, MD.

Nominations were declared closed.

Nominations were declared open for the position of *SPEAKER, HOUSE OF DELEGATES* (Two-year term of office).

S. N. Stone, MD, Oklahoma City, was nominated by James B. Pitts, MD.

Nominations were declared closed.

Nominations were declared open for the position of *VICE-SPEAKER, HOUSE OF DELEGATES* (Two-year term of office).

Jack D. Fetzer, MD, Woodward, was nominated by the Northwest County Medical Society.

Nominations were declared closed.

Nominations were declared open for the position of *DELEGATE TO THE AMA, Position I* (Two-year term of office).

Harlan Thomas, MD, Tulsa, was nominated by Roger Haglund, MD.

Nominations were declared closed.

Nominations were declared open for the position of *ALTERNATE DELEGATE TO THE AMA, Position I* (Two-year term).

Orange Welborn, MD, Ada, was nominated by the Pontotoc County Medical Society.

Nominations were declared closed.

Nominations were declared open for the position of *DELEGATE TO THE AMA, Position II* (Two-year term).

Scott Hendren, MD, Oklahoma City, was

(Continued on Page 297)

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## Officers Elected For Oklahoma Allergy Society

At the annual meeting of the Oklahoma Allergy Society held May 12th, 1974, officers were named for the coming year. They are Manuel Brown, MD, Tulsa, President; George Winn, MD, Oklahoma City, Vice-President; and Leon Horowitz, MD, Tulsa, Secretary-Treasurer.

Guest speaker for the event was Elliott Middleton, MD, Medical Director of CARIH, Denver, Colorado. His topic was "The Newer Mechanisms and Chemical Control of Asthma." □

## FDA Announces Workshops On Federal Diagnostic X-Ray Standards

A Federal standard for diagnostic x-ray equipment becomes effective August 1st of this year. This equipment standard primarily applies to manufacturers and assemblers but users are also affected.

Because the final standard was extensively revised and amended since first proposed in 1971, it is not surprising that many individuals affected are not yet knowledgeable about its full implications.

Under the standard, x-ray manufacturers are responsible for producing equipment and components that perform according to requirements of the standard. Assembler's primary responsibility is to install the system according to the manufacturer's specifications and to use the type of components called for by the standard. He must certify that these two conditions have been met by filing specified forms with the Food and Drug Administration's Bureau of Radiological Health, the State Radiation Control Agency, and the purchaser.

One of the principal protection provisions of the standard requires machines to be capable of restricting the x-ray beam to the size of the film or fluoroscopic image receptor. The standard also contains provisions intended to make it possible for operators to reproduce more consistently a given image quality for given voltage, current, and time settings. This capability, in combination with good x-ray examination techniques, will tend to minimize film retakes and unnecessary exposure.

To familiarize persons who are affected by the new standard, especially commercial installers

and users who may perform their own installations, with their responsibilities under the new regulations, workshops are being conducted by the Food and Drug Administration. These one-day sessions are being held in various parts of the US. Persons interested in attending are urged to contact the FDA Radiation Control Officer in their region for additional information. Workshops will also include discussions of proposed federal requirements involving resale of used x-ray equipment. □

## New Publication Announced

*Military Medicine*, a new publication, aimed at providing a channel of communication for a world wide network of physicians, pharmacists, surgeons, biological scientists, behavioural scientists, nursing specialists and military strategists applying their competencies to some component of military medicine, will be published three times a year.

The journal's field of interest is in the evaluation and refinement of this branch of medical science through competent research which it aims to integrate on an international plane. As there is no single profession to be defined for military medicine, it freely draws from various medical professions without in any way disturbing them. Authoritative and constructively critical book reviews of the most important books in the field of military medicine will be included.

Subscriptions, \$30.00 a year, may be mailed to K. K. ROY (Private) LTD. 55 Gariahat Road, P.O. Box 10210, Calcutta 700019, India. □

## Acapulco Trip Popular With Doctors

Over fifty reservations have been received for the OSMA sponsored trip to Acapulco, Mexico, next January 15th-21st. Oklahoma physicians and their wives will stay in the luxurious Hotel Las Brisas.

A special postgraduate medical seminar has been arranged with Mexican physicians.

A deposit of \$75.00 per person is required to hold a spot on the Acapulco trip. Reservation deadline is early August. □

## DEATH

### **C. RILEY STRONG, MD 1920-1974**

Immediate Past-President of the Oklahoma State Medical Association, C. Riley Strong, MD, died in El Reno, June 10th, 1974.

A native of Nashville, Kansas, Doctor Strong received his premedical work at Oklahoma State University and was graduated from the University of Oklahoma College of Medicine in 1943. After 36 months as a medical officer with the US Navy, he established his practice in El Reno.

Doctor Strong was quite active in all aspects of the medical association's affairs, having served on the Board of Trustees for many years and later fill-

ing the post of Chairman of the Board for three years.

He was a charter member of the Oklahoma Chapter of the American Academy of Family Physicians an organization he later served as President; a charter Fellow of the American Academy of Family Physicians; an official Delegate to the Congress of Delegates of the AAFP; had served as National Chairman of the Student and Resident Affairs Committee of the group; and had served four years on the AAFP Commission on Membership.

In addition, Doctor Strong was very active in all his community activities and had served on the El Reno Board of Education for 20 years. □

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### Miscellaneous Advertisements

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(Continued from Page 292)

nominated by M. Joe Crosthwait, MD.

Nominations were declared closed.

Nominations were declared open for the position of *ALTERNATE DELEGATE TO THE AMA*, Position II (Two-year term).

Rex Kenyon, MD, Oklahoma City, was nominated.

Nominations were declared closed.

#### *IX. NOMINATIONS OF TRUSTEES AND ALTERNATE TRUSTEES:*

Nominations were declared open for *TRUSTEE AND ALTERNATE TRUSTEE* for the following Trustee Districts (Three-year term of office).

##### *DISTRICT VI:*

Reporting on the caucus of representatives from District VI, the following nominations were made:

*James B. Eskridge, III, MD* and *John Blaschke, MD*, were nominated for the positions of Trustees and *Perry Lambird, MD*, and *Kent Braden, MD*, were nominated for the positions of Alternate Trustees.

##### *DISTRICT VII:*

*Casey Truett, MD*, Norman, was nominated for the position of Trustee and *Clinton Gallaher, MD*, Shawnee, was nominated for the position of Alternate Trustee.

##### *DISTRICT VIII:*

*Paul Bischoff, MD*, and *William Benzing, MD*, Tulsa, were nominated for the positions of Trustees and *Harold Calhoon, MD*, and *Myra Peters, MD*, Tulsa, were nominated for the positions of Alternate Trustees.

##### *DISTRICT IX:*

*Thomas Gafford, MD*, Muskogee, was nominated for the position of Trustee and *Burdge Green, MD*, Stilwell, was nominated for the position of Alternate Trustee.

#### *X. INTRODUCTION OF COUNCIL AND COMMITTEE REPORTS AND RESOLUTIONS:*

The Speaker stated that in order to save time a list of reports and resolutions was included in their portfolios, and that an item by item introduction was not necessary.

Doctor Strong asked that the rules of procedure be waived in order to adopt resolutions commending Doctors Roth and Price.

#### *XI. NECROLOGY REPORT:*

The Vice-Speaker of the House of Delegates, S. N. Stone, MD, read the Necrology Report. (A copy of the report is attached and made a part of the minutes).

#### *XII. ADJOURNMENT OF OPENING SESSION:*

The Opening Session of the House of Delegates was adjourned at 4:10 p.m.

#### **NECROLOGY REPORT**

1973-74

Forrest P. Baker, MD, Talihina  
James W. Childs, MD, Tulsa  
Samuel M. Davis, MD, Chickasha  
William H. Doyle, MD, Muskogee  
Forrest S. Etter, MD, Bartlesville  
Edward H. Fite, MD, Muskogee  
Harry C. Ford, MD, Miami  
Marvin B. Glismann, MD, Oklahoma City  
John L. Glomset, MD, Oklahoma City  
Rex M. Graham, MD, Miami  
Floyd Gray, MD, Oklahoma City  
Paul L. Grosshart, MD, Tulsa  
Walter G. Hathaway, MD, Lone Grove  
Philip W. Head, MD, Miami  
Fred B. Hicks, MD, Oklahoma City  
Ben M. Huckabay, MD, Antlers  
James R. Huggins, MD, Oklahoma City  
Wallis S. Ivy, MD, Duncan  
Roger G. Johnson, MD, Frederick  
Hugh C. Jones, MD, Oklahoma City  
Ray H. Lindsey, MD, Pauls Valley  
James D. Moffett, Jr., MD, Ardmore  
William R. Moore, MD, Oklahoma City  
Harold G. Nelson, MD, Stillwater  
Tom I. Parker, MD, Oklahoma City  
Chester A. Pavy, MD, Tulsa  
Grider Penick, MD, Oklahoma City  
Killis C. Reese, MD, Tulsa  
Henry L. Regier, MD, Lawton  
Monte V. Stanley, MD, Tulsa  
Cary W. Townsend, MD, Edmond  
Henry C. Traska, MD, Oklahoma City  
Granville I. Walker, MD, Norton, Connecticut  
M. M. Wickham, MD, Tahlequah  
Alpha M. Williams, MD, Shawnee

#### *CLOSING SESSION*

##### *I. CALL TO ORDER:*

The Closing Session of the 68th Annual Meeting of the House of Delegates was called to order by the Speaker, Roger J. Reid, MD, at 2:50 p.m., May 15, 1974, in the Myriad Convention Center, Oklahoma City.

##### *II. REPORT OF THE CREDENTIALS COMMITTEE:*

Donald F. Mauritsen, MD, Chairman of the Credentials Committee, announced a quorum present.



### III. ANNOUNCEMENTS:

Doctor Strong presented a gift of appreciation to Mrs. Daniel R. Storts, Tulsa, President, OSMA Woman's Auxiliary and Doctor Richardson presented a gift of appreciation to Mrs. C. Riley Strong, El Reno, First Lady of the OSMA.

### IV. REPORTS OF REFERENCE COMMITTEES:

*All reports considered by the House of Delegates are attached and approved and made a part of these minutes.*

#### REPORT OF REFERENCE COMMITTEE NO. III:

Presented by: Charles Atkins, MD, Oklahoma City, Chairman

Mr. Speaker and Members of the House of Delegates, your reference committee gave careful and deliberative consideration to the items referred to it and makes the following report:

#### *Item I. Report of the Financial Aid to Education Committee:*

Mr. Speaker, your committee considered this report and wishes to commend the Financial Aid to Education Committee and the Board of Directors for the Foundation for Community Medical Care for their work and recommends that this report be adopted.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

#### *Item II: Report of the Medical Center Liaison Committee:*

Mr. Speaker, your committee found this to be a most informative report and wishes to recommend that it be adopted. However, there are some considerations to be made as follows:

On page 4 in the second full grammatical paragraph under Medical School Liaison, the second sentence should read, "Two years ago the admissions procedure and board was revised and now there are fifteen physicians from the private sector, three from the OSMA and three from the Oklahoma Academy of Family Physicians. The remainder of the admissions committee are from full and part time faculty." In addition, the Admissions Committee has fourteen full-time faculty members and nine senior medical students.

In the 3rd grammatical paragraph there is a typographical mistake, "the 1975 starting class will have 156 students."

Your committee wishes to recommend that some type of program or tour of the Oklahoma University Health Sciences Center be planned

for the next Oklahoma Medical Summit meeting.

*Mr. Speaker, I move the adoption of this portion of the report as amended. The motion was seconded.*

*Doctor Calhoun made a motion that the OSMA must have a more effective liaison with the medical center. The OSMA must somehow exert a positive influence on the medical school if they anticipate better support. Doctor Crosthwait seconded the motion and it was carried as amended.*

#### *Item III: Report of the Council on Professional Education:*

Mr. Speaker, your committee finds the proposed plans of this council to be highly commendable.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

#### *Item IV: Report of the Council on Public Health:*

Mr. Speaker, your committee considered this council report by sections. The portion of the report dealing with the medical conditions in the Oklahoma penal institutions was considered separately.

The committee found the report as a whole to be acceptable.

On page 17 of the Task Force Report, the following sentence should be added to the conclusion: "The medical director should be selected by a Health Advisory Council named to assist the Corrections Department in this function."

On page 18 the last sentence in the first non-underlined paragraph should be deleted and the following addition made: "We suggest that the administration, the Corrections Department, and legislative leaders appoint a Health Advisory Council to select the medical director and assist him in his endeavors. The Oklahoma State Medical Association may be called upon for appropriate assistance." The remainder of that paragraph naming the council should be kept in the report.

*Mr. Speaker, I move the adoption of the report on the Council on Public Health and the Task Force Report as amended. The motion was seconded and it carried.*

#### *Item V: Report of the Council on Socioeconomic Activities:*

Mr. Speaker, your committee recommends that the functions of the Peer Review Committee be more widely publicized to association members. Peer Review deals mainly with matters of fees, and the association should have



knowledge of this council.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item VI: Resolution No. 2:*

Your reference committee recommends that this resolution be approved.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item VII: Resolution No. 4:*

Your reference committee recommends that the final resolve of this resolution be amended to read as follows: "RESOLVED, That the Oklahoma State Medical Association commend the University of Oklahoma School of Medicine for its support of the Family Medical Program, and, further, recommends continued improvement in both the financial support and the availability of inpatient care space for this valuable program."

*Mr. Speaker, I move the adoption of this resolution as amended. The motion was seconded and it carried.*

*Item VIII: Resolution No. 11:*

Your committee recommends that the resolve in this resolution be changed to read as follows: "RESOLVED, That an ad hoc committee be appointed by the President of the Oklahoma State Medical Association with instructions to explore every possible legal method to change this practice and obtain equity in the reimbursement to physicians."

*Mr. Speaker, I move the adoption of this resolution as amended. The motion was not seconded and carried.*

Doctor Calhoon asked for re-consideration of this resolution because he supported it. Doctor Nelson stated the reason the resolution was written was because the people do not know why they were there.

*A substitute motion was made that Resolution No. 11 be adopted. The motion was seconded and it carried as amended.*

*Item IX: Resolution No. 13:*

Your committee recommends that this resolution be adopted with the following resolve being added to it: "BE IT FURTHER RESOLVED, That the OSMA should enter into a contract with the University of Oklahoma Medical School Office of Continuing Education to formulate a plan to carry out the interest of this resolution. Such contract should be for an amount of \$1,000."

*Mr. Speaker, I move the adoption of this resolution as amended. The motion was seconded*

*and it carried.*

*Item X: Resolution No. 15:*

Your committee felt that the intent of this resolution was to call for an expansion of the power of the State Board of Medical Examiners. Therefore your committee recommends that the first resolve be amended to read as follows: "RESOLVED, That the OSMA, through its House of Delegates, recommends that the Legislature of the State of Oklahoma empower the Oklahoma State Board of Medical Examiners to establish limiting rules for the licensure of non-U.S. citizen foreign medical graduates." The final two resolves of this resolution should be stricken.

*Mr. Speaker, I move the adoption of this resolution as amended. The motion was seconded and it carried.*

*Item XI: Resolution No. 16:*

Your committee received information about the workings of the various state aid and vocational rehabilitation programs. This resolution could be applied only partially to any of them. If adopted as written, we would be calling upon non-medical trained personnel to make medical judgments. This is clearly not the intent of the author of this resolution. While a re-evaluation of such programs may be in order, this resolution would not accomplish that end. Your committee therefore recommends that this resolution do not pass.

*Mr. Speaker, I move the adoption of this portion of the report.*

After further discussion, the House decided to approve the resolution.

*Mr. Speaker, I move the adoption of this resolution. The motion was seconded and it carried.*

*Item XII: Resolution No. 17:*

Your committee was extremely sympathetic to the situation outlined by the author of this resolution. The mal-distribution of physicians is a continuing problem. Unfortunately, there are no simple solutions.

If this resolution was adopted, we would be inviting the Oklahoma Legislature to impose itself directly into the training of physicians. This is a situation that cannot be allowed and should not be recommended by this House of Delegates.

Your committee recommends that this resolution do not pass.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*



*Item XIII: Resolution No. 26:*

Again, as with the last resolution, your committee was dealing with the problem of physician mal-distribution. The proposal outlined in this resolution was considerably more palatable to your committee than that found in the last resolution that we considered.

However, your committee does wish to amend the resolves in this resolution to read as follows: "RESOLVED, That the Oklahoma State Medical Association request that the College of Medicine give high priority to geographical representation of students in its admissions policy, providing that the applicants from these areas present equal qualifications to study medicine. With this accomplished, it is felt that the medical school enrollment will adequately represent all of the state equally; and be it further

"RESOLVED, That each geographical area be represented as nearly as possible according to population on the Admissions Committee for the University of Oklahoma College of Medicine."

*Mr. Speaker, I move the adoption of this resolution as amended. The motion did not carry.*

*Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and it carried.*

**REPORT OF REFERENCE COMMITTEE  
NO. I**

Presented by: Robert R. Hillis, MD, Chairman

Mr. Speaker and Members of the House of Delegates, your Reference Committee gave careful consideration to the items referred to it and makes the following report:

*Item I: Report of the President of the OSMA:*

Doctor C. Riley Strong, outgoing president of the OSMA has served his association in many important capacities throughout his entire career. He has further distinguished himself during the past year by ably serving as president of the association, and the report he presented to the House of Delegates on May 12th was but another example of his concern about the affairs which confront us, and your committee recommends that the report of the president be approved. Further, your committee, speaking on behalf of all state physicians, commends Doctor Strong for his splendid service as our state leader during this past year.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and*

*it carried.*

*Item II: Report of the Board of Trustees:*

This report recaps principal actions taken by the Board of Trustees during the past year and, again, the Board has functioned well in the management of association business.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item III: Supplemental Report of the Board of Trustees:*

Your committee recommends that this report be approved, with one suggested change: In Item 14 of the Supplemental Report, the Board of Trustees adopted an incentive plan to pay commissions to county medical societies for the collection of AMA dues, with AMA dues funds received by the OSMA in January being commissioned at the rate of 2% . . . funds received in February to be commissioned at the rate of 1% . . . and a ½ of 1% commission to be paid for AMA dues received by the OSMA in March. Since the AMA commission payable to the OSMA will be based on the prime interest rate current at the time, and this interest rate may fluctuate year-to-year, the OSMA could be unduly rewarded or unfavorably penalized by offering county medical societies a fixed commission rate for the collection of AMA dues. Thus, it is recommended that the OSMA Board of Trustees review and establish an equitable commission rate each year based on the prime interest rate which will be employed at that time by the AMA in computing its commissions.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item XI: Resolution No. 24:*

Your reference committee joins Doctor C. Riley Strong in expressing appreciation of Doctor Thomas C. Points for his twelve years' service as an Alternate Delegate to the American Medical Association. Your reference committee, therefore, recommends adoption of resolution No. 24.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

Doctor Points accepted a plaque in appreciation for his service as an Alternate Delegate to the AMA.

*Item IV: Report of the Secretary-Treasurer:*

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item V: Report of the Committee on Planning:*



*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item VI: Resolutions 1, 12 and 14:*

Resolutions 1 and 12 called for a change in the OSMA bylaws to make the payment of AMA dues voluntary, while resolution 14 requests that the OSMA continue its program to require AMA membership as a condition of state association membership.

Resolution No. 1, authored by the Tulsa County Medical Society, stipulates specific amendments to accomplish a change to voluntary membership, and the Constitution and Bylaws Committee also provide specific amendments to accomplish this objective although it demurred on taking a position on the issue.

Your reference committee was surprised by the limited number of witnesses who appeared at the open hearing to speak on this important subject, and it was not felt that there was sufficient discussion to give committee members an accurate insight as to the attitude of the OSMA membership. Within the membership of the reference committee itself, there was a significant division on the question of whether or not AMA dues should be voluntary or required . . . of the seven committee members present for the meeting on May 13th, four favored a continuation of the required AMA membership policy and three favored adoption of a policy of voluntary membership.

Because of this division within the committee ranks, and because there was not a large volume of testimony at the open hearing on this subject, the committee adopted the following position regarding the disposition of resolutions 1, 12 and 14:

"The reference committee defers to the House of Delegates the decision on whether or not membership in the American Medical Association continue to be required as a condition of OSMA membership. If the OSMA House of Delegates, as the group most representative of the entire association membership, decides to make AMA dues voluntary, then the reference committee recommends that the enabling amendments cited in the Report of the Constitution and Bylaws Committee be adopted."

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item VII: Report of the Constitution and Bylaws Committee:*

In the preceding section recommendations have been made as to the amendments neces-

sary to change AMA dues to a voluntary basis. Regarding other portions of the Constitution and Bylaws Committee, your reference committee has the following recommendations:

Your reference committee agrees that the name of the OSMA Council on Professional Education be changed to the Council on Continuing Medical Education, and agrees with other suggestions in the Report of the Constitution and Bylaws Committee, with the exception of Item 4 in the committee's report having to do with "membership in the House of Delegates."

It is the feeling of your reference committee that membership in the OSMA should be a sufficient qualification for designation by a county medical society as a Delegate or Alternate Delegate to the OSMA. If a county medical society wishes to impose further qualifications on its selection as a Delegate or Alternate Delegate to the OSMA, this should remain within the province of the county medical society.

Therefore, it is recommended by the reference committee that Section 1.01 of Chapter VI of the bylaws be reworded as follows: "Qualifications. Delegates and Alternate Delegates must be members in good standing of the Oklahoma State Medical Association."

Your reference committee agrees with the OSMA Board of Trustees that the Chairman of the Board of Trustees should be a member of the Executive Committee of the OSMA. Therefore, the amendment suggested in the Report of the Constitution and Bylaws Committee regarding the composition of the Executive Committee should be changed as follows: "Amend Chapter X, Section 5.00 to read . . . 'Executive Committee. The Executive Committee shall consist of the General Officers of the association as defined in Chapter VI, Section 1.00, and the Chairman of the Board of Trustees'."

Regarding changes suggested by the Constitution and Bylaws Committee on the delinquency date for the collection of dues, your committee feels that the Constitution and Bylaws should be left undisturbed as to the date a member would be suspended (March 31) and the date for forfeiture of membership (May 31) should be left undisturbed. (Dates, for suspension and revocation of membership, are satisfactory for these purposes, in the opinion of the reference committee). However, before penalties of this type may be exacted by the OSMA, there should be an admonishment to all physicians who have not paid their dues by February 1st. In this respect, your reference committee recommends that Chapter II, Section 1.04 be



amended as follows: "1.04. Due Date. Dues shall be payable on January 1 for the year on which levied, and should become delinquent if not paid before February 1 of that year."

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item VIII: Report of the Council on Insurance:*

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item IX: Resolution No. 3:*

This resolution is laudable in its intent, and in this respect it is fully supported by members of your reference committee. However, adjustments might be needed from the standpoint of legislative strategy and practical achievability. The reference committee, therefore, recommends that resolution No. 3 be adopted by the House of Delegates and referred to the OSMA Legislative Committee to determine the feasibility of the worthwhile legislative objective set forth in the resolution and to make any adjustments in the resolution which might be necessary to achieve its intent from a legislative standpoint.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Item X: Resolution No. 22:*

Here again, resolution No. 22 set forth a very worthwhile policy regarding health insurance for the newborn, a policy which the resolution author apparently intends to draw to the attention of the Oklahoma Legislature in the form of a model bill. The reference committee recommends that resolution 22 be adopted and referred to the OSMA Legislative Committee for appropriate action.

*Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.*

*Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and it carried.*

#### **REPORT OF REFERENCE COMMITTEE NO. II:**

Presented by: Floyd Miller, MD, Tulsa, Oklahoma, Chairman

Mr. Speaker and Members of the House of Delegates, your Reference Committee No. II gave careful consideration to the several items referred to it and submits the following report:

*Item I: Report of the Council on Professional and Intervocational Relations:*

Mr. Speaker, your committee considered this report in its entirety and wishes to commend the members of this council. This report is an excellent commentary on the many activities of this association carried out by small committees and groups. We would suggest that all members of the House and association study this report, and recommend that the report be adopted as a whole.

#### **RECOMMENDATION:**

*Mr. Speaker, I move the adoption of this report. The motion was seconded and it carried.*

*Item II: Report of the Council on Public Policy:*

Mr. Speaker, your committee considered this report by sections.

#### **Section I: Council Activities**

**A-Public Relations Program**—Your reference committee considered the recommendations dealing with OSMA's public relations efforts. Several members of the committee considered this to be one of the highest priorities of the association. We concur in the recommendations listed by the Council and would suggest that they be implemented as expeditiously as possible.

#### **RECOMMENDATION:**

*Mr. Speaker, we recommend the adoption of this portion of the report. The motion was seconded and it carried.*

**B-PSRO Repeal Campaign**—This is an informative report that expresses the dilemma of organized medicine in regard to this major legislative issue. The association leadership has done extremely well in honoring its obligations to the membership in seeking the repeal of this law. The fact that all of Oklahoma's Congressional Delegation is receptive to the wishes of OSMA speaks well for our relationship with our congressional delegation. We concur ". . . there does not seem to be any justification at this time . . ." for a ". . . massive and expensive public information program . . ." on PSRO. However, it is the feeling of your committee that Oklahoma physicians should begin now putting into motion the machinery to inform their patients of the serious effects of government intervention into the practice of medicine.

#### **RECOMMENDATION:**

*Mr. Speaker, we recommend the adoption of this portion of the report. The motion was seconded and it carried.*

**C-Improvement of the State Legislative Activities**—Your reference committee recommends the adoption of this report with special emphasis that all members of the association



become more cognizant and involved in political activities and do as is recommended by the Council ". . . lend their full support to the Oklahoma Medical Political Action Committee . . ."

**RECOMMENDATION:**

*Mr. Speaker, we recommend the adoption of this portion of the report. The motion was seconded and it carried.*

*D-Federal Legislation.* This is an informative report and compares extremely well the major national health insurance bills. No issue is of more pressing importance than this. This report should be required reading for every member of the association.

**RECOMMENDATION:**

*Mr. Speaker, we recommend the adoption of this portion of the report. The motion was seconded and it carried.*

*Section II: Report of the State Legislative Committee:* Mr. Speaker, your reference committee would like to congratulate and commend the members of this committee for the outstanding work that they have done on our behalf at the State Capitol. The legislative program of the association needs the support of all Oklahoma physicians to become the potent force of which it is capable.

**RECOMMENDATION:**

*Mr. Speaker, we recommend the adoption of this portion of the report. The motion was seconded and it carried.*

*Section III: Report of the Medical Heritage Committee:*

*Mr. Speaker, we recommend the adoption of this portion of the report and move the adoption of the Report of the Council on Public Policy as a whole. The motion was seconded and it carried.*

*Item III: Resolution No. 5-PSRO Repeal:*

Mr. Speaker, inasmuch as the second part of the resolve of Resolution No. 5 has been accomplished, (7 out of 8 Oklahoma representatives to the U.S. Congress have endorsed our efforts to repeal PSRO), and in view of the fact that the Council on Public Policy has recommended several programs that will accomplish the first part of the resolve, it is the recommendation of your reference committee that Resolution No. 5 be referred to the Council on Public Policy with instructions that the Public Relations Committee develop information to be used by physicians in their offices informing their patients of the deleterious effects of government intervention in medicine and that the general public relations efforts of the association include information about the harmful effects of government intervention in the private practice of

medicine.

**RECOMMENDATION:**

*Mr. Speaker, we recommend that Resolution No. 5 be referred to the Council on Public Policy with instructions as stated. The motion was seconded and it carried.*

*Item IV: Resolution No. 6-PSRO Repeal:*

*Mr. Speaker, your reference committee recommends that Resolution No. 6 be adopted. The motion was seconded and it carried.*

*Item V: Resolution No. 7-PSRO:*

This resolution requests that the association enter as amicus curiae a lawsuit to declare the PSRO law unconstitutional. Your reference committee considered this resolution in great detail. We had the benefit of considerable testimony and had available written advice of OSMA's legal counsel. Due to the many ramifications of this resolution and the potential expense to the association, your reference committee offers the following substitute resolution:

*Resolve:* That the OSMA Board of Trustees consider carefully the action of AMA at its upcoming meeting in June in regard to legal action to declare the PSRO law unconstitutional. In the event that AMA does not take legal action to declare said law unconstitutional, then OSMA will enter into negotiations with other state medical societies and, if a substantial number concur and agree, then OSMA will join others in legal action seeking declaration that the PSRO law is unconstitutional.

**RECOMMENDATION:**

*Mr. Speaker, your reference committee recommends that this substitute resolution be adopted in lieu of Resolution No. 7. The substitute resolution was seconded and it carried.*

*Item VI: Resolution No. 8-PSRO and Resolution No. 10-PSRO Repeal:*

The thrust of Resolution No. 8 and 10 are to impose upon federally financed hospitals the same requirements that would be imposed upon private hospitals if PSRO is implemented rather than repealed. Your reference committee considered these resolutions together and offers the following substitute resolution:

*Resolve:* That PSRO standards be applied to all federal institutions receiving tax funds and caring for patients receiving government medical benefits including VA hospitals, Public Health Service hospitals, Indian Health Service hospitals and military hospitals.

*Be It Further Resolved:* That the legislative department of the American Medical Association be requested to draft legislation accomplishing this result, and



*Be it Further Resolved:* That the leadership of the Oklahoma State Medical Association present this proposed legislation to Oklahoma's Congressional Delegation for introduction in the 93rd Congress.

*An amendment was made to this motion that this resolve only be applied if PSRO is not repealed by the federal legislation, and, at that time, OSMA would like to put in at the national AMA level a moratorium of PSRO and that it be applied to federal hospitals for at least two years before PSRO is placed on physicians.*

*The amendment was seconded and it carried.*  
*Item VII: Resolution No. 20 – Physicians Bill of Rights:*

Mr. Speaker, your reference committee concurs in the philosophy of Resolution No. 20. However, we feel that a clarification should be made in paragraph 10 of the resolution. We would suggest that the following language be substituted for paragraph 10: "Only licensed physicians and dentists approved by the medical staff shall be authorized to admit patients or discharge them from hospitals and other facilities."

**RECOMMENDATION:**

*Mr. Speaker, your reference committee recommends that Resolution No. 20 be adopted as amended. The motion was seconded and it carried.*

*Item VIII: Resolution No. 21–Hospital Staff Privileges:*

Your reference committee recommends that the resolve of Resolution No. 21 be expanded as follows:

*Resolve:* That the Oklahoma State Medical Association opposes any requirements to pay for staff privileges in any hospital except for dues that are voted and administered exclusively by the hospital staff.

**RECOMMENDATION:**

*Mr. Speaker, your reference committee recommends the adoption of Resolution No. 21 as amended. The motion was seconded and it carried.*

*An amendment was made to change the wording to medical staff instead of hospital staff. The amendment was seconded and it carried.*

*Item IX: Resolution No. 23 – Protection of Patients' Health*

Mr. Speaker, the House of Delegates in a special session, April 6, 1974, accepted a report of the Oklahoma Foundation for Peer Review which sets forth recommendations to be followed by the association in regard to PSRO. In

summary, these recommendations included a requirement that the OSMA Board of Trustees and AMA Delegates continue diligent efforts for the repeal of PSRO; that the Board of Trustees and AMA Delegates seek modification of the law; and that a public information campaign be conducted if necessary. Therefore, the first resolve of Resolution No. 23 is now being carried out by the association. The principle involved in the second resolve of Resolution No. 23 is, in essence, the current policy of the association. However, the semantics of the second resolve might create some confusion about OSMA's position in regard to PSRO. The reference committee recommends that the second resolve be reworded as follows:

*Resolve:* That in the event this dangerous legislation is not repealed or modified in such a way as to protect the health of the American people, physicians, as caretakers of the health of the American people shall then consider a position of non-participation.

**RECOMMENDATION:**

*Mr. Speaker, we recommend the adoption of Resolution No. 23 as amended. The motion was seconded and it carried.*

*Item X: Resolution No. 27 – Medical Legislation:*

Resolution No. 27 requests that the House of Delegates authorize the employment of another lobbyist during the legislative session to work on state legislation. Your Reference Committee heard testimony from various members about the importance of physicians' contact with their elected officials. We reviewed carefully the Report of the Council on Public Policy and the Report of the State Legislative Committee and considered their recommendations when discussing Resolution No. 27. The Council on Public Policy has indicated that the most important ingredient in a successful legislative program is physician involvement. The Council also recommended several things that will improve the communications between the association, its members and the Oklahoma legislature. It is the feeling of the Reference Committee that the intent of Resolution No. 27 is not necessarily to hire a lobbyist, but to improve the lobbying of OSMA by whatever means are necessary and we feel the suggestions of the Legislative Committee and the Council on Public Policy will accomplish that end.

It is also the opinion of the Reference Committee that the Board of Trustees has authority to and should exercise its judgment in the hiring of people to discharge the responsibilities of the association.



RECOMMENDATION:

*Mr. Speaker, your Reference Committee recommends that Resolution No. 27 not be adopted. The motion was seconded and it carried.*

Mr. Speaker, this concludes the report of Reference Committee II. On behalf of the Committee, I should like to express appreciation to the many individuals who appeared before the Committee to give us a thoughtful expression of their views.

*Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and it carried.*

V. ELECTION OF OFFICERS AND TRUSTEES:

The following Officers, Trustees and Alternate Trustees were elected by acclamation since all nominees were uncontested:

*Arnold G. Nelson, MD*, Midwest City, was elected to the office of President-Elect.

*Roger J. Reid, MD*, Ardmore, was elected to the office of Vice-President.

*S. N. Stone, MD*, Oklahoma City, was elected to the office of Speaker, House of Delegates.

*Jack D. Fetzer, MD*, Woodward, was elected to the office of Vice-Speaker, House of Delegates.

*Harlan Thomas, MD*, Tulsa, was elected to the office of AMA Delegate, Position I.

*Orange M. Welborn, MD*, Ada, was elected to the office of Alternate Delegate to the AMA, Position I.

*Scott Hendren, MD*, Oklahoma City, was elected to the office of AMA Delegate, Position II.

*Rex Kenyon, MD*, Oklahoma City, was elected to the office of AMA Alternate Delegate, Position II.

*Trustees District VI: Oklahoma County*

*Trustee: James B. Eskridge, III, MD*, Oklahoma City

*Trustee: John Blaschke, MD*, Oklahoma City

*Alternate: Perry Lambird, MD*, Oklahoma City

*Alternate: Kent Braden, MD*, Oklahoma City

*Trustee District VII: Cleveland, Creek, Lincoln, Okfuskee, Pottawatomie & McClain Counties*

*Trustee: Casey Truett, MD*, Norman

*Alternate: Clinton Gallaher, MD*, Shawnee

*Trustees District VIII: Tulsa County*

*Trustee: Paul Bischoff, MD*, Tulsa

*Trustee: William Benzing, MD*, Tulsa

*Alternate: Harold Calhoon, MD*, Tulsa

*Alternate: Myra A. Peters, MD*, Tulsa

*Trustee District IX: Adair, Cherokee, McIntosh, Muskogee, Okmulgee, Sequoyah & Wagoner*

Counties

*Trustee: Thomas Gafford, MD*, Muskogee

*Alternate: Burdge F. Green, MD*, Stilwell

VI: NEW BUSINESS:

Doctor Reid gave special thanks to the OSMA staff members for their assistance in preparing the annual meeting.

VII: ADJOURNMENT:

The 68th closing session of the House of Delegates adjourned at 4:45 p.m.

Report of the  
PRESIDENT  
(APPROVED)  
May 12, 1974

Mr. Speaker, Delegates, Fellow Physicians, Members and Guests:

This has been a most interesting year. From the beginning of my term of presidency in Tulsa last year, it has been one crisis after the next with PSRO. The best laid plans of mice and men often fail. I had wanted to visit each district society, but because of many pressing problems, I was unable to visit all societies. I enjoyed my visits to Ponca City, Clinton, Bartlesville, Lawton, Tulsa and Oklahoma City.

I wish to thank each and everyone of you for your help and cooperation. This great meeting that we are starting today will be — in my opinion — the finest meeting that any of us have ever attended. It has not come about in a slipshod way, nor, did it grow like Topsy. It has been necessary for the committees to work hard and long hours in taking care of each little detail. Our very fine executives, Don Blair, David Bickham, Ed Kelsay and their staff have done a tremendous amount of work; as well as Harl Stokes and his staff. Kent Braden and his Summit Steering Committee have been invaluable as well as all the committees that have worked on this meeting. The scientific program under Arnold Nelson is one of the finest you will ever attend. We have sold all our exhibit space and could have sold more, had the space been available. I would like to have a standing ovation for all the men and ladies who have worked so diligently in producing this meeting.

During the past year, PSRO has been foremost in problems facing our profession. In May, states desiring to be designated as one PSRO met in Washington, D.C. and during that time we Oklahomans all visited with our Congressmen, as did the other states present. The entire Oklahoma Delegation supported us with letters to Secretary Weinberger. We have had



very excellent rapport with the Oklahoma Osteopathic Association in the PSRO problems. For those of you who may have missed the April 6th Special Session of the House of Delegates, the approved reports of the PSRO matter will be printed in this month's *Journal*.

The Board of Trustees has authorized resolutions sent to the AMA on repeal of PSRO. As you know, the entire Oklahoma Delegation in Congress has given us excellent support on repeal. At Chicago at the annual meeting in June of the AMA, Oklahoma will be in the forefront in helping change the policy of the AMA on this issue.

I hope each and everyone of you will visit the State Office. It has been re-decorated and is in first-class condition. We should all be proud of our Headquarters Building.

I have checked the last three presidents' messages to you and I am sorry to report that we still have most of the problems that have beset our profession for the last few years. I am not a prophet of doom, but I try to be practical in my beliefs. I'm thinking about National Health Insurance; it is not whether or not we will have it, but, what type bill the Congress will pass. It is my feeling the entire Congress favors some type

of National Health Insurance. We must all be alert to this and try to influence to the best of our ability, a fair and just law. I do not feel the AMA's Medcredit Bill — although it has many sponsors — will have a chance of passage in the Congress. The health of our nation has become a political football and will continue to be for some time. There are even some members of our profession who favor National Health Insurance!!

We have many problems in our own State: The Health Sciences Center is having great financial difficulties because of the University Hospital. The problems of rural physicians are always with us. Even though we now have classes of 150 students in the Medical School, we still do not have enough rural physicians. I only hope that the young physicians will begin to see the need of the people in the smaller communities and find that they can have a very useful and happy way of life in the smaller towns.

I must interject a little bit of my philosophy into this address. I have always felt that as long as you can get up each morning and look at yourself in the mirror as you start shaving and a new day, and you are able to say to yourself: "I am helping my fellow-man; I am honest with my fellow-man; and I hope the world is a better

## **SECOND BIENNIAL SYMPOSIUM ON DISEASES OF THE VULVA AND VAGINA**

presented by

**THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON  
DIVISION OF CONTINUING EDUCATION**

in collaboration with

**BAYLOR COLLEGE OF MEDICINE  
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY**

**November 6th, 7th, and 8th, 1974**

**Houston, Texas**

This intensive review of the diseases of the vulva and vagina has been designed primarily for the physician specializing in gynecology. It will be presented by a distinguished faculty selected for their particular knowledge in the field and their ability to communicate effectively. Professors Herman L. Gardner and Raymond H. Kaufman are in charge of the program.

The course will consist of a brief review of the pathophysiology and the management of a large group of diseases of the vulva and vagina and in-depth presentations and discussions of important entities such as herpes genitalis, "leukoplakia," chronic recurrent candidiasis, DES induced adenosis, etc.

This program is accredited by the Council on Medical Education of the American Medical Association and the American Academy of Family Physicians. Certification of attendance will be provided attendees.

**For further information contact:** The Office of the Director, The University of Texas Health Science Center at Houston, Division of Continuing Education, P.O. Box 20367, Houston, Texas 77025.



place to live because of my efforts;" then, I feel I am doing the right thing and I know I am living the good life.

I would like to suggest to each of you and your wives that you will enjoy the poem in the President's Page of the April issue of the *OSMA Journal*.

I consider it a great honor to have been your president for the past year. As your spokesman, I have tried to represent each and everyone of you as I would want to be represented. There are several past-presidents here in this audience who have served our profession well and are respected by all of us. I hope, as I join this elite group, that I may be as helpful to our new president, Jack Richardson, and future presidents, as they have been to me. I thank each and everyone of you for allowing me to serve as your president.

Report of the  
BOARD OF TRUSTEES  
(APPROVED)

This report summarizes principal actions taken by the Board of Trustees since the last annual meeting. Actions taken by the Board at its May 12th meeting are contained in the accompanying Supplemental Report.

Actions reported from the October 28th and April 5th meetings of the Board are as follows:

1. The Board approved an annual audit of the association's accounts for the fiscal year ending May 31, 1973, which showed a surplus of \$977.00.

2. A revised budget based on prorata income to be derived from a \$20 dues increase for 1974 was approved by the Board. This budget indicated an anticipated surplus of \$4,300.00 for the fiscal year ending May 31, 1974.

3. A hospitality suite for Delegates to the American Medical Association was approved for the Anaheim, California meeting of the AMA. The reception . . . a one-night affair . . . was also hosted by the Kansas Medical Society and the Arkansas Medical Society. Cost to the OSMA was less than \$200.

4. The Board authorized a \$500 expenditure to redecorate space in the OSMA building which is leased to the Oklahoma County Medical Society.

5. On recommendation of the Planning Committee, the Board of Trustees approved the submission of six resolutions to the American Medical Association House of Delegates at the 1973 Clinical Session.

6. On recommendation of the Planning Committee, the Board of Trustees authorized the Executive Director to spend up to \$8,000 to refurbish the older portion of the OSMA office building. To date \$7,293 has been spent for the approved purposes. There were sufficient reserves to carry out this capital improvement project.

7. The Board continues to receive slow response from the Governor in making appointments to the State Board of Medical Examiners which, by law, are to be made from nominations submitted by the OSMA. In 1972, the term of Doctor William A. Matthey expired, but to date the Governor has made no appointment. Nominees for the position are Doctor Matthey, Doctor Charles L. Tefertiller, and Doctor David Fried. Doctor Matthey has continued to serve for nearly two years pending a new appointment.

Last October, the Board of Trustees nominated three physicians for the position on the State Board of Medical Examiners formerly held by Doctor Tom Parker, deceased. Nominees are Doctor Kent Braden, Doctor Perry Lambird, and Doctor Kenneth Whittington. There has been no action by the Governor, and it has been about seven months since the nominations were made.

8. The Board of Trustees appointed Doctor Harold Calhoon, Tulsa, to the position of Alternate Trustee, District VIII. Also, Doctor Casey Truett, Norman, was appointed Alternate Trustee, District VII.

9. A beautiful plaque was presented on October 28th to Alpha L. Johnson, MD, recipient of the 1973 A. H. Robins' "Physicians Award for Community Service." Doctor Johnson, El Reno, had been nominated by the Board for this honor in April.

10. Two OSMA-sponsored tours were approved by the Board for 1974, the "South Pacific Adventure" (now completed) and the "European Adventure" scheduled for departure in September. In addition, the Board has approved two special trips in 1975: A one-week trip to Acapulco departing on January 15th (accommodations at the unique Las Brisas), and a tour of Hawaii, November 28-December 7, to attend the AMA Clinical Convention (seven days in Honolulu and three days on the island of Maui). The regular two-week sightseeing tour schedule will be decided at the Board's May 12th meeting and will be reported in the Board's Supplemental Report.

11. Life membership applications were consi-



dered by the Board of Trustees, and the following were approved for action by the House of Delegates: Earl M. Woodson, MD, Poteau; Nolan C. Riley, MD, Holdenville; C. W. Moore, MD, Stillwater; Kenneth Bonham, MD, Enid; John F. Burton, MD, Oklahoma City; Ephraim Goldfain, MD, Oklahoma City; Joe M. Parker, MD, Oklahoma City; John W. Shackelford, MD, Oklahoma City; Oscar White, MD, Oklahoma City; and Felix O. Durham, MD, Tulsa.

12. Dues Exemption Petitions were approved for three physicians based on reports from county medical societies.

13. Fifty-Year Pins were awarded to John F. Burton, MD, Oklahoma City, and to Ephraim Goldfain, MD, Oklahoma City.

14. Based on a poll of the membership last May, the Board of Trustees activated the Board of Directors of the Oklahoma Foundation for Peer Review in accordance with the poll's affirmed question: "The Oklahoma Foundation for Peer Review should be activated to undertake preliminary investigation of the PSRO law and the forthcoming regulations with the final decision to apply for PSRO involvement remaining vested with the House of Delegates."

15. The Board of Trustees approved a modification in the OSMA Employee's Pension Plan . . . from a fully insured plan to a split-funded program. The change had been previously recommended by the association's Council on Insurance.

16. At its April 5th meeting, the Board of Trustees met with representatives of the Oklahoma Foundation for Peer Review and with the President of the Dikewood Corporation, Walter Wood, PhD. The Foundation's comprehensive report on the PSRO law and the Dikewood operational concept were discussed at length. Both were approved and passed on to the House of Delegates for its action at a Special Session on April 6th.

17. The Board of Trustees reports the following breakdown of membership:

Active Members	2,089
Active Dues-Exempt Members	28
Applications Pending	82
Life Members	167
Affiliate Members	6
Honorary Members	9
Junior Members	128

Total	2,509
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Last year, total membership was 2,387, of which 2,018 were paying full OSMA dues.

# Supplemental Report BOARD OF TRUSTEES (APPROVED AS AMENDED)

At the annual meeting of the Board of Trustees held at 9:30 a.m. on May 12, the following actions were taken:

1. John A. McIntyre, MD, Enid, was elected to a one-year term as Chairman of the Board of Trustees; Frank Clark, MD, Ardmore, was elected Vice-Chairman.

2. The Board reviewed the report of the Council on Public Policy, and endorses the recommendations contained on page 10, to-wit: That increased postage be budgeted for the State Legislative Committee . . . that an automatic typewriter be leased for legislative and other purposes . . . and that the leasing of a WATTS line be investigated.

3. In reviewing the report of the Constitution and Bylaws Committee, with reference to amendments to the Bylaws which would establish the Executive Committee as being composed of the OSMA officers, the Board of Trustees recommends that the Chairman of the Board of Trustees be included in the Bylaws as a member of the Executive Committee.

4. The Board nominated the following physicians for one seven-year term on the State Board of Medical Examiners: Francis First, MD, Checotah; Thomas Gafford, MD, Muskogee; and Thomas Rhea, MD, Idabel.

5. The Board appointed Arnold G. Nelson, MD, as a Trustee of the OSMA Employees' Pension Plan.

6. Harris D. Riley, MD, Oklahoma City, was reappointed to a new three-year term on the Editorial Board.

7. Harry Wilkins, MD, Oklahoma City, was nominated by the Board as the recipient of the 1974 A.H. Robins' Physicians Award for Community Service.

8. The following physicians were nominated for one appointment to the Health Department's "Health Facilities Advisory Council": M. Joe Crosthwait, MD, Oklahoma City; Worth M. Gross, MD, Tulsa; and Arnold G. Nelson, MD, Midwest City.

9. The following physicians were nominated for one appointment to the Health Department's "Hospital Planning Advisory Council": Frank Clark, MD, Ardmore; Alpha Johnson, MD, El Reno; and Orange M. Welborn, MD, Ada.



10. The Board of Trustees approved the 1974-75 Board of Directors of the Oklahoma Medical Political Action Committee.

11. Life membership applications were approved for the following: James R. Huggins, MD, Oklahoma City (Posthumously); William E. Eastland, MD, Oklahoma City; Evelyn Miller, MD, Tulsa; Homer A. Ruprecht, MD, Tulsa; Raymond E. Daily, MD, Bixby; Hays R. Yandell, MD, Tulsa; Thomas J. Hardman, MD, Tulsa; James G. Moore, MD, Tulsa; Francis W. Pruitt, MD, Tulsa; Alpha M. Williams, MD, Shawnee (Posthumously); Addison B. Smith, MD, Stillwater; Howard L. Puckett, MD, Stillwater; George S. Wilson, MD, Enid; Francis M. Duffy, MD, Enid; Paul B. Champlin, MD, Enid; Kenneth W. Bonham, MD, Enid; Raymond G. Jacobs, MD, Enid; James L. Nicholson, MD, Norman; Charles E. Cook, MD, Norman; Gertrude Nielsen, MD, Norman; Iva S. Merritt, MD, Norman; Edwin A. McGrew, MD, Norman; Philip F. Herod, MD, El Reno; J. L. LeHew, Jr., MD, Guthrie; Phil Devanney, MD, Sayre; J. P. Irby, MD, Altus; Seth D. Revere, MD, Chickasha; W. F. Dean, MD, Ada; Ollie McBride, MD, Ada; I. J. Haugen, MD, Ada.

12. Because of insufficient numbers of physicians in Murray County, the Board of Trustees recommends to the House of Delegates that the Murray County Medical Society be dissolved.

13. Regarding site selection for the 1975 OSMA annual meeting, the Board of Trustees requests that the House of Delegates authorize the Board to make this decision pending a careful analysis of "Oklahoma Medical Summit," a decision which can be made in June.

14. The Board adopted an incentive plan for commissioning County Medical Societies for the collection of AMA dues, as follows: The OSMA will pay 2% commission for all AMA dues received in January . . . 1% for all AMA funds received in February . . . and one-half of 1% for all AMA dues received in March.

It is recommended that the House of Delegates approve the Board's action in this respect.

14. It is recommended that the OSMA Board of Trustees review and establish an equitable commission rate each year based on the prime interest rate which will be employed at that time by the AMA in computing its commissions.

15. Resolution No. 27, authored by Arnold G. Nelson, MD, was considered favorably by the Board of Trustees and passed on to the House of Delegates for final action.

16. The Board considered and approved five (5) resolutions authored by the "Committee on

Planning" for submission to the AMA House of Delegates.

17. The Board authorized the President of the OSMA to appoint a Travel Committee which will review and select foreign tours to be sponsored by the Association.

18. The Board of Trustees adopted the attached policy statement regarding conditions at the University of Oklahoma Health Sciences Center, and recommends its adoption by the House of Delegates and its release to the press. In addition, the Board approved a petition on the same subject to be circulated for physicians' signatures during the "Oklahoma Medical Summit" meeting.

*Proposed Policy Statement  
Regarding the University of Oklahoma  
Health Sciences Center*

The Oklahoma State Medical Association is gravely concerned that confusion about necessary funding for the University of Oklahoma Health Sciences Center, and especially about its affiliated University Hospital, will affect the quality or availability of educational programs which are vital to the citizens of Oklahoma in terms of producing adequate health manpower today and in the future.

The 3,300 medical doctors in the state, over half of whom are graduates of the OU College of Medicine, have not been officially involved in the management of the Health Sciences Center or in the financial studies of the past two years which have been inspired or authorized by the Governor, the Oklahoma Legislature, the University of Oklahoma Board of Regents and the Board of Regents for Higher Education. However, we can't believe that mutually agreeable solutions to the financial problems can't be found through good-faith negotiations between the Governor, the Regents groups, the Health Sciences Center officials and the responsible leaders of the Oklahoma Legislature. An impasse over the question of what constitutes adequate funding to sustain the educational programs and to keep University Hospital open as a vital health services center for the citizens of Oklahoma will not serve any useful purpose; rather, it could result in depriving Oklahomans of needed health practitioners and health services.

Oklahoma *must* be able to afford adequate funding of the OU Health Sciences Center . . . Oklahoma *cannot* afford to tolerate a financial dilemma at the expense of losing or severely handicapping the state's only complete health manpower training center.

The Oklahoma State Medical Association is not directing criticism toward any of the parties



or individuals officially involved in the current controversy. Instead, the Board of Trustees and the House of Delegates of our association are appealing to the responsible parties . . . those in positions of management and those with financial responsibility . . . to quickly take whatever steps are necessary to assure the uninterrupted continuity of essential services and training programs now underway for the benefit of our citizens.

The association will be immediately responsive, if asked, to participate in finding solutions to the financial problems at the OU Health Sciences Center. We have faith that all parties concerned will place the preservation of the Center and related facilities above vested interests they may have.

Considered by: The Oklahoma State Medical Association Board of Trustees, May 12, 1974

Report of the  
SECRETARY-TREASURER  
(APPROVED)

*Financial Statement*

The association's fiscal year ends on May 31st, at which time a complete audit of all accounts will be prepared. In order to provide the Delegates with an indication of the financial status of the OSMA at this time, however, the following estimates of income and expense (excluding the annual meeting) are presented:

**INCOME**

Membership Dues	\$215,000
Interest Income	4,000
Building Lease-	
Okla. County	4,200
Journal	28,000
Membership Directory	650
AMA Commissions	2,000
Miscellaneous	1,300
Estimated Total Income	\$255,150

**EXPENSE**

Fixed Expenses (Gen'l.	
Administration)	\$157,000
Depreciation	5,200
Councils	
and Committees	2,500
Journal	38,500
OSMA News	2,500
Student Loan Fund	11,000
In-State Travel	4,400

(Continued on Page 321)

# Rondomycin<sup>®</sup>

## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS: Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



WALLACE PHARMACEUTICALS  
CRANBURY, NEW JERSEY 08512



(Continued from Page 316)

Out of State Travel	18,500
Okla. Council for Health Careers	2,000
Mortgage Payments (Building)	5,485
Loan-Okla. Fdn. for Peer Review	2,500
Estimated Total Expense	\$249,585
Estimated Surplus	\$5,565

At the beginning of the year, the OSMA was budgeted for an estimated surplus of \$4,300, so the preceding estimate of a surplus of \$5,565 looks quite favorable. This surplus has been made possible by the 1974 dues increase; otherwise, 1974 would have been a deficit year if operations at the OSMA office had been carried out at the previous level without additional revenue to offset the effects of inflation. In addition, \$2,000 budgeted for educational television was not spent due to a change in programming by the Postgraduate Office at the OU College of Medicine.

An unbudgeted expense occurred when the OSMA Board of Trustees authorized a \$5,000 loan to the association-sponsored Oklahoma Foundation for Peer Review to carry out investigative studies regarding PSRO per the directive of the House of Delegates. However, only \$2,500 has actually been loaned to OFPR at this time, and the Secretary-Treasurer is advised that the balance of the loan will not be needed by OFPR during this fiscal year and perhaps not at all (depending on PSRO developments this summer). In addition, the Oklahoma Osteopathic Association has contributed \$1,000 to OFPR as its proportionate share of the costs of the study, and the Insurance Company of North America, OSMA's professional liability insurance carrier, has contributed \$1,000 to OFPR. The Oklahoma Foundation for Peer Review could use these new funds to carry out further studies, or could use them to partially repay the OSMA, or a combination of both.

*Journal* printing costs were not increased by the Transcript Press during the last year despite skyrocketing costs of paper. However, the OSMA has been advised that printing costs will be increased an overall 9.8% in the coming fiscal year . . . bad news, but exceedingly reasonable under the circumstances. To offset this additional expense, *Journal* advertising rates have been increased 10% and a major effort will be made by OSMA staff to sell more pages of advertising during the coming year.

The OSMA has accelerated the pay-out of the construction loan for the office building ex-

pansion program. At present, the balance on the \$50,000 loan is only \$1,087.49. Thus, OSMA fixed expenses will drop about \$4,400 during the next year and, in addition, we will receive the full benefit of the \$20 dues increase in 1974 (only five-twelfths of the new revenue accrued to the 1973-74 fiscal year).

The OSMA is participating with the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians in "Oklahoma Medical Summit" . . . a combined annual meeting of the three organizations. The selling power of the three groups is producing exhibit income and ticket sales of approximately \$60,000 . . . an unprecedented figure for a medical convention in Oklahoma (or in much larger states). Expenses could run only about \$50,000, and a division of the surplus would net the OSMA about \$3,300 if these estimates are correct. This anticipated income has not been included in the preceding financial statement, and if it materializes, the OSMA would be blessed with an unexpected windfall.

#### 1974-75 Budget

The budget below is only a guide to the financial operations of the OSMA, but is useful in apportioning income to the various expense categories and provides the officers, trustees and staff with some general goals in managing the OSMA's resources during the year. Adjustments may need to be made in the budget by the Board of Trustees during the year, because all contingencies cannot be seen twelve months in advance.

#### INCOME

Membership Dues	\$240,000
Interest Income	6,000
Building Lease-Okla. County	4,200
Journal	29,000
Membership Directory	8,000
AMA Commissions	3,000
Miscellaneous	2,800
Total Estimated Income	\$293,000

#### EXPENSE

Fixed Expenses (Gen'l. Administration)	\$170,000
Depreciation	6,000
Councils and Committees	
Public Policy	\$4,000
Insurance	1,000
Professional Education	2,500
Socioeconomic	1,000
Public Health	500
Prof. & Intervocational Relations	500



Sub Total	9,500
Journal	44,000
OSMA News	2,000
Membership Directory	5,000
Student Loan Fund	11,000
In-State Travel	6,000
Out of State Travel	20,000
Okl. Council for Health	
Careers	2,000
Mortgage payments	1,100
Total Estimated Expenses	\$276,600
Estimated Surplus	\$16,400

Again, annual meeting income and expense are not included in the budget since the consolidated meeting in Oklahoma City (OSMA, OCCS and OAFP) is authorized for only one year on an experimental basis, and the site and arrangements for the 1975 meeting of the OSMA are unknown at this time.

#### RECOMMENDATIONS:

1. It is recommended that the tentative budget be approved by the House of Delegates subject to necessary adjustments as may be made by the Board of Trustees.

2. It is recommended that the automobile mileage allowance for persons traveling on OSMA business be increased from 10 cents to 13 cents per mile.

#### Report of the COMMITTEE ON PLANNING (APPROVED)

##### *Committee Members*

Stanley R. McCampbell, MD, Oklahoma City,  
Chairman  
C. Riley Strong, MD, El Reno  
M. Joe Crosthwait, MD, MWC  
Kent Braden, MD, Oklahoma City  
Arnold G. Nelson, MD, Midwest City  
Charles E. Smith, Jr., MD, Oklahoma City  
Jack L. Richardson, MD, Tulsa  
Roger J. Reid, MD, Ardmore  
C. Alton Brown, MD, Oklahoma City  
Marion C. Wagnon, MD, Del City  
Kenneth W. Whittington, MD, Bethany

#### SECTION I

##### *Renovation of OSMA Office Building*

The original section of the OSMA office building was constructed in 1957, and much of the furniture and other furnishings utilized in pri-

vate offices and conference rooms were purchased by the OSMA prior to the construction of the building. In addition, wall coverings in private offices installed in 1957 had been water damaged more than 10 years ago. The building was expanded in 1971 adding a beautiful Board of Trustees conference room and creating two additional conference rooms on the end of the building . . . and extending a larger filing area and work room on the other end of the building. The Board room had never been completely furnished in terms of matching chairs to accommodate the seating capacity of the room. Another conference room created by the expansion program was never fully furnished in a manner to fulfill its purpose.

After receiving estimates from the OSMA staff, the Committee on Planning approved new wall coverings where needed in the older portions of the building, new furniture and decorations for the executive offices (including a new office created for the president of the OSMA), matching side chairs to extend the seating capacity of the Board of Trustees conference room and new lighting fixtures in the older portions of the building (candlepower generated by the old fixtures was far below acceptable reading levels). These recommended expenditures were presented to the OSMA Board of Trustees by the Committee on Planning, and October 28, 1973, the Board of Trustees authorized the OSMA Executive Director to spend up to \$8,000 for these purposes.

#### SECTION II

##### *Out-Of-State Travel Policy*

Physicians traveling out of state on OSMA business have been paid \$50 a day per diem plus coach class air travel. It was determined by the Committee on Planning that the cost of hotel accommodations and meals in the principal cities normally hosting medical meetings could not be covered by the \$50 per day allowance (single rooms are frequently as much as \$40 a day). Moreover, physicians, who travel on OSMA business are sacrificing practice income by taking these trips, and it was felt by the Committee on Planning that they should at least be rewarded by traveling first class. Thus, the Committee on Planning recommended to the OSMA Board of Trustees that the per diem be increased to \$75, and that first-class travel be authorized. On October 28th, the Board of Trustees adopted this change in the travel policy.



### SECTION III

#### *Resolutions to the AMA*

The Committee on Planning authored (and achieved approval from the OSMA Board of Trustees) five resolutions to submit on behalf of the association to the American Medical Association House of Delegates at its 1973 Clinical Convention in Anaheim, California. Four of these resolutions dealt with changing the AMA's policy toward PSRO, and one related to abolishing the contingency fee in professional liability law suits. For the forthcoming annual meeting of the AMA House of Delegates in Chicago in June, the committee is proposing to the OSMA Board of Trustees six additional resolutions. Once again, emphasis is on modifying the AMA's stance toward PSRO. Four of the resolutions deal with this subject, one advocates a "Bill of Rights" for physicians (to protect against deleterious effects of government control), and one is supportive of the American pharmaceutical manufacturing industry.

#### Report of the CONSTITUTION AND BYLAWS COMMITTEE

May 12, 1974

(APPROVED AS AMENDED)

#### *Committee Members*

George H. Garrison, MD, Oklahoma City,  
Chairman

E. N. Lubin, MD, Tulsa

Paul H. Rempel, MD, Enid

Leo E. Yates, MD, Oklahoma City

Arnold G. Nelson, MD, Midwest City

Clinton Gallaher, MD, Shawnee

The bylaws of the Oklahoma State Medical Association provide that the Constitution and Bylaws Committee has the responsibility of studying amendments to the bylaws and constitution as proposed by members of the association or by component societies. In addition, your committee may originate amendments to the Constitution and Bylaws, if it so desires. In either case, the recommendations of the committee are to be forwarded to the House of Delegates.

During this past year your committee has considered six different areas of change recommended for the bylaws. Each of these six areas will be taken up separately.

#### 1. AMA Membership.

The Tulsa County Medical Society has proposed an amendment to the OSMA Bylaws

which would "delete the requirement for mandatory membership (in the AMA) from the bylaws . . .". Resolution Number 1 contains the proposed amendment.

The question as to whether or not the AMA membership requirement of the OSMA should be changed has arisen numerous times in the past. On each of these occasions your committee has determined that it did not wish to take a stand on the issue, but simply recommended the wording to be followed by the House of Delegates if it chose to remove this requirement. This year the six members of your committee voted as follows: three voted to take no position, one recommended that the mandatory requirement be retained, and two recommended that it be dropped.

While the committee cannot be unanimous in making a recommendation on this subject, it does recommend that if the OSMA House of Delegates chooses to drop the mandatory requirement, the following changes should be made in the bylaws: Amend Chapter I, Section 1.00 of the bylaws by deleting the entire last sentence of the section. All of the wording, with the exception of the Section number and the title of Chapter II, Section 2.00, should be deleted, and the following wording inserted in its place . . . "Members of this association who elect to become members of the American Medical Association shall pay AMA dues and assessments as levied for their appropriate classification of membership. AMA dues and assessments should be collected and remitted by component societies in like manner as state association dues and assessments." Chapter V, Section 7.036 should be amended by inserting the words ". . . involving AMA members . . ." to make the first sentence of that section read, "Judicial decisions of the Board of Trustees *involving AMA members* may be appealed to the Judicial Council of the American Medical Association in accordance with that organization's constitution and bylaws."

Further, in the event the House of Delegates chooses to make AMA membership voluntary, your committee recommends that all county medical societies be instructed by the House of Delegates to amend their bylaws accordingly.

#### 2. Council on Professional Education Name Change.

It has been recommended that the name of the Council on Professional Education be changed to the Council on Continuing Medical Education. This could be done by amending Chapter IX, Section 1.00 by deleting the phrase,



"Council on Professional Education", and replacing it with "Council on Continuing Medical Education."

Your committee recommends that this name change be adopted.

### 3. Membership Categories.

Last year the House of Delegates adopted various changes in the membership categories of the association. Because of the numerous changes, there were some inadvertent oversights. As an example, while the bylaws called for the creation of an honorary member, there is a requirement that any such person must hold a degree of Doctor of Medicine. This, obviously, would limit the usefulness of this membership category.

The following is a list of the various changes and the recommendations of your committee.

Your committee recommends that Chapter I, Section 1.012 be amended to read as follows: "MEDICAL DEGREE. A person who does not hold the degree of doctor of medicine may be named an honorary member, as provided in Section 2.06 of this chapter."

Your committee recommends that Chapter I, Section 2.00, be amended to read, "Members of the association shall be classified as Active Members, Active Dues Exempt Members, Life Members, Affiliate Members, Honorary Members, Corresponding Members, Junior Members and Student Members." This is an addition of Honorary, Corresponding and Student Members.

Your committee recommends that the last sentence of Chapter I, Section 4.00, be amended to read, "Life, Affiliate, Corresponding, and Junior Members who leave the state may maintain membership through the component societies of their original affiliation." This amendment simply adds "Corresponding" to this section of the bylaws.

The termination of memberships needs to be changed in the bylaws. Chapter I, Section 5.03 deals with the termination of Life and Affiliate Memberships only. Your committee recommends the following change to include Corresponding and Honorary Memberships to this termination process: "TERMINATION OF LIFE, HONORARY, CORRESPONDING AND AFFILIATE MEMBERSHIPS. The House of Delegates, upon recommendation of the Board of Trustees, may revoke any Life, Honorary, Corresponding or Affiliate Membership by a

two-thirds vote of the members present, for any breach of ethics or conduct unbecoming the honor of such membership."

The exemption of certain categories of memberships from dues was overlooked when the membership categories were changed last year. Chapter II, Section 1.031 needs to be amended to provide that certain categories of members will have complete exemption from dues and assessments. Your committee recommends that the first sentence of this section be amended to read, "The following classifications of members shall be completely exempt from payment of dues and assessments: (a) Life, Honorary, Student and Junior Members; . . . etc." This is an addition of Honorary and Student Members.

The section of the bylaws dealing with partial exemptions also needs to be amended. Your committee recommends that Section 1.032 of Chapter II should have the following subsection added: "(c) Affiliate and Corresponding Members shall be required to pay partial dues in an amount to be specified by the Board of Trustees."

### 4. Membership in the House of Delegates.

Last year the reference committee that considered the report of the Constitution and Bylaws recommended that the bylaws be amended to remove the requirement that a physician must have been an active member of the OSMA prior to election by a county medical society as its delegate to the OSMA House of Delegates. The report stated, "This rule contradicts the right of the county medical society to establish its own rules regarding its own representation in the House of Delegates and, in the opinion of the reference committee, it should be removed from the OSMA bylaws."

This can be accomplished by striking Section 1.01 "QUALIFICATIONS" of Chapter IV and rewording it as follows: "QUALIFICATIONS. Delegates and Alternate Delegates must be members in good standing of the Oklahoma State Medical Association."

After careful consideration, your committee recommends that this change not be adopted. Such a change could be compared to an attempt by the various states to establish their own requirements for membership in the United States Congress.

### 5. Executive Committee.

The reference committee that considered this committee's report at last year's House of Delegates also recommended that a change be made in the method used by the association to select the Executive Committee of the associa-



tion. Last year the bylaws were amended to provide that this committee could make administrative decisions.

At the present time the Executive Committee is appointed by the Board of Trustees, based upon nominations submitted by the President-Elect of the association.

Usually the Executive Committee of any organization consists of the organization's general officers. Your committee recommends that the following amendment be made to Chapter X, Section 5.00, to formalize the choosing of the Executive Committee: "EXECUTIVE COMMITTEE. The Executive Committee shall consist of the general officers of the association as defined in Chapter VI, Section 1.00, and the *Chairman of the Board of Trustees.*"

The section cited in the above recommendation defines the general officers as the President, President-Elect, Immediate Past President, Vice-President, Secretary-Treasurer, Speaker of the House of Delegates, and Vice-Speaker of the House of Delegates.

#### 6. Dues Delinquency Date.

The American Medical Association has changed the delinquency date of dues to April 30. The association office staff needs time between the OSMA's delinquency date and the AMA's delinquency date to prepare the necessary paperwork to transfer the national dues money and membership lists to the AMA.

Your committee recommends that the delinquency date for dues be left undisturbed in the bylaws as March 31. Chapter II, Section 1.04 should read as follows: "Due Date. Dues shall be payable on January 1 for the year on which levied, and should become delinquent if not paid before February 1 of that year."

The above change would also necessitate a change in Section 1.07 SUSPENSION, to read "Failure to pay dues by March 1 shall result in the automatic suspension of membership in the association . . .". Section 1.08 FORFEITURE OF MEMBERSHIP should be changed to read, "Failure to pay dues by May 1 shall result in the automatic termination of membership in the association . . .". This latter is a change from May 31.

The net result of all of the above changes would be to move all dues dates up one month to correspond to the AMA dates.

#### Section 1.01-Chapter 4

"Qualifications. Delegates and Alternate Delegates must be members in good standing of the Oklahoma State Medical Association."

## Report of the COUNCIL ON INSURANCE May 12, 1974 (APPROVED)

### *Council Members*

C. Alton Brown, MD, Oklahoma City, Chairman  
Martin H. Andrews, MD, Oklahoma City  
Howard A. Bennett, MD, Bartlesville  
William G. Bernhardt, MD, Midwest City  
Robert W. Kahn, MD, Oklahoma City  
William M. Leebron, MD, Elk City  
Thomas Lowrey, MD, Yukon  
C. E. Woodard, MD, Tulsa

### SECTION I

#### *Group Term Life Insurance*

This program is underwritten by the Massachusetts Mutual Life Insurance Company and has been in effect since 1956.

Prior to age 60, \$50,000 coverage is offered; from age 60 through 64, \$25,000 coverage is available; and \$10,000 coverage can be obtained from age 65 through age 69. Accidental death benefits are included providing additional benefits of \$100,000 prior to age 60 (\$200,000 additional for death by accident on a common carrier). Other features include dismemberment and loss of sight benefits, waiver of premium if disabled, and private flying coverage.

Since the inception of the plan through April 1, 1974, total claims and expenses incurred have been \$1,080,000. About 260 physicians' lives are protected under this competitive program at a risk of more than \$5 million. Total annual premium is about \$60,000.

Loss experience during the last year has been excellent, and a cumulative underwriting loss over the 17-year period of some \$35,000 could be totally eliminated, thus paving the way for dividends to policy holders during future favorable years.

### SECTION II

#### *Disability Income Insurance*

The OSMA disability income insurance program is underwritten by the Washington National Insurance Company.

Up to \$2,500 a month indemnity is offered for periods of disability due to illness or accident. There are optional waiting periods before disability coverage begins, and either a 5-year or



"to age 65" benefit period may be selected for disabilities due to illness (lifetime benefits are payable in case of accident).

There are presently about 600 OSMA members protected under this very fine program. Premium income is about \$265,000 a year.

Loss experience has been optimum over the years of sponsoring this program . . . ranging from 74 to 76 per cent of premium. However, losses are currently running at a higher rate, and the Council on Insurance will be attentive to this trend in an effort to avoid a premium increase, if possible.

### SECTION III

#### *Overhead Expense Insurance*

This program is underwritten by the Continental Casualty Insurance Company.

The program indemnifies a physician against the cost of keeping his office open during periods of disability. From \$300 to \$1,500 a month coverage may be purchased for a disability period of 18 months. Benefits may be used to pay the actual overhead costs, including employees' salaries, during periods of disability. Premium costs are tax deductible.

Loss experience has been exceedingly low over the years. At present, there are 153 members insured under the plan at a gross annual premium of \$24,000, while claims paid last year were only \$10,000.

The Council on Insurance has instructed our insurance agent to seek a premium reduction from Continental Casualty. Additional enrollments will be pushed during the next year as this program is an excellent vehicle for a physician to obtain a tax-deductible extension of his income protection during periods of sickness.

### SECTION IV

#### *Professional Liability Insurance*

The OSMA's professional liability insurance program continues to be a model for the nation. Contrary to national trends, premiums under the OSMA Insurance Company of North America plan remained unchanged for 1974, and we are continuing to offer our members excellent malpractice protection at about one-half the market price. Nearly 2,000 OSMA members purchase this bargain-rate high quality plan at a gross annual premium of \$1,152,000 . . . this coverage would cost

\$2,000,000 at the current manual rate in Oklahoma if it were not for the OSMA-sponsorship arrangement with INA.

It is hoped that the premium cost can be held relatively stable in the coming years, but we must all recognize that malpractice claims and awards are on the upswing across the nation. While we have been favored by a better malpractice climate than other states, the number of claims and the amount of the dollar demands are continuing to rise in Oklahoma.

The Council on Insurance will undertake various claims prevention programs during the coming year in order to help stabilize our position as much as possible. We have an excellent working relationship with the Insurance Company of North America, and while it is entirely possible that we cannot continue to hold a stable premium in the face of increasing threats, we are satisfied that INA will continue to provide a market for us at the best possible rates dictated by the circumstances.

### SECTION V

#### *Excess Limits Liability Insurance*

During the past year, INA withdrew from the excess limits market in Oklahoma (they had withdrawn from all other plans except the OSMA's in 1972). The company made this decision due to its adverse loss experience on a national basis, and the OSMA program was phased out a year later even though there had been no losses at all attributable to our plan.

The INA program provided malpractice coverage as high as \$5,000,000 (with the first \$100,000 to be protected by the basic INA program described in the preceding section of this report).

When the company reluctantly announced its decision to phase out of the excess limits field, the Council on Insurance was given ample time to replace the coverage. Our agent, the C. L. Frates Company, contacted 28 companies in an attempt to duplicate the cost and the quality of the INA protection. Only one company, CNA/Transcontinental, met the criteria established by the Council, as follows:

1. The insurer must be financially sound.
2. Rates must be competitive with the INA (the best rates available).
3. The company must agree to use defense attorneys selected by the OSMA.
4. The company must agree to market the excess limits policy through INA agents as a companion to the INA basic coverage, and must

agree to write coverage for all OSMA members insured for basic protection (\$100,000) by the INA.

To give the House of Delegates an idea of the market situation, 18 of the 28 companies contacted did not want our business, and all others except CNA/Transcontinental would not conform to our cost or management specifications.

There were some administrative problems in making the changeover to CNA, but the program should operate smoothly in coming years. Costs and coverages of the new plan are not quite as attractive as the previous program in some instances, but the Council on Insurance is satisfied that CNA has offered the best program by far that we can hope to obtain in this shaky market.

Nearly 1,200 of our members buy this extra malpractice protection.

## SECTION VI

### *Major Medical-Hospital Insurance*

The new health insurance program is being promoted strongly by our agents. It is underwritten by the Washington National Insurance Company.

A number of options are available in order that a physician may design the program to his own needs. . . annual deductibles of \$250, \$500 or \$1,000 may be chosen. . . daily room allowance ranging from \$40 to \$75 is available. . . the maximum benefit per illness may be selected as low as \$24,000 to as high as \$45,000. . . and a maximum surgical allowance (highest procedure) is flexible within the range of \$1,800 to \$3,000.

The plan, which pays both in and out of the hospital, provides 100% of room charges, 80% of miscellaneous hospital services and supplies, 100% of the surgical schedule, 80% of non-surgical medical services, and 80% of prescribed medicine costs.

As an example of rates, an OSMA member age 44 may insure himself and his wife at a cost of \$330.80 a year for the following benefits. . . \$50 a day room allowance, \$2,000 maximum surgical fee, and \$30,000 in benefits per illness.

The program was undertaken to fill a need in the OSMA's insurance portfolio. . . it is selling well. . . and further improvements are being undertaken by the Council on Insurance.

The plan is also available to employees of OSMA members with a \$100 deductible.

## Report of the COUNCIL ON CONTINUING MEDICAL EDUCATION

May 12, 1974  
(APPROVED AS AMENDED)

### *Council Members*

Kenneth Whittington, MD, Bethany, Chairman

Royce B. Means, MD, Lawton

Ralph L. Buller, MD, Hydro

Clarence P. Taylor, MD, Ada

John W. Drake, MD, Oklahoma City

James C. Smith, MD, Tulsa

John A. Blaschke, MD, Oklahoma City

Wendell L. Smith, MD, Tulsa

Irwin H. Brown, MD, Oklahoma City

David E. Browning, MD, Tulsa

James F. Tagge, MD, Enid

James D. Loudon, MD, Shawnee

Y. E. Parkhurst, MD, Miami

Jack W. Parrish, MD, Seminole

William E. Dalton, MD, Oklahoma City

Because of a multitude of problems with overriding priority, your Council has not been active during the past year. However, the inter-relationship of some of the present areas of OSMA activity and future involvement of this council cannot be overlooked.

Specifically, the law which created the so-called Professional Standards Review Organizations specifies that they should be primarily educational in nature. In addition, a great deal of the past year has been spent in preparing for this meeting, Oklahoma Medical Summit. While one of these activities may or may not be in the future, the other has come to pass.

A survey of the report of this council over the past several years indicated continuing frustration on the part of its members. Each year for the past several years the council has asked the question, "What is our purpose?" Unfortunately, in each case it was really unable to answer.

It is obvious that the OSMA cannot compete in the area of offering continuing medical education for physicians. We do not have the staff, time or finances, but above all we do not have the expertise in education. We cannot expect to compete with the medical centers, specialty societies, regional medical program, voluntary health agencies, and other organizations whose primary functions are educational.



Each year the educational issue of *JAMA* lists over 2,500 different medical education possibilities for physicians.

If your council is to function, it must find and fill a need that is not being met by some other more qualified organization.

Such a need is easy to find, almost too easy. The advent of Medicare, Medicaid, insurance companies, and the Economic Stabilization Program have placed physicians in a position of needing socioeconomic information. It almost seems that it is now more important to know how a physician runs his front office, than how he actually practices medicine.

Whether this is a need the physicians want filled, remains to be seen. Your council is anticipating that there will be interest in this area and wishes to recommend that the House of Delegates authorize it to plan and execute at least four regional seminars on the business aspects of medical practice. These seminars would discuss such things as the use of Current Procedural Terminology, Relative Value Studies, billing and collections, Medicare and Medicaid claim procedures for patients, resolving fee disputes, etc., etc.

Like councils in the past, the present one is unsure of the acceptance of such programs. However, we are using this meeting, Oklahoma Medical Summit, to ascertain the feelings of our physician-members toward such regional programs. Attached to this report is a copy of a questionnaire that the council is circulating among the physicians attending this meeting.

These questionnaires will be tabulated and the council will use the answers and comments from them to determine its future course of action.

#### RECOMMENDATIONS:

1. The council recommends that the House of Delegates authorize it to prepare a series of regional programs on the socioeconomics of medical practice, if the survey being conducted during Oklahoma Medical Summit indicates an interest on the part of our physician-members in this type of activity.

2. The council has received a request from the American Medical Association to study the possibility of the OSMA establishing its own program of accreditation in continuing medical education for community hospitals,

state level specialty societies, county medical societies and voluntary health agencies. Such accreditation would assure that physicians wishing to use local continuing medical education activities could apply it toward credit for the AMA Physician's Recognition Award. It is recommended that the House instruct the Council to study the feasibility of such an accreditation program.

#### SEMINAR QUESTIONNAIRE OSMA COUNCIL ON PROFESSIONAL EDUCATION

Your Council on Professional Education is attempting to determine what type of continuing educational programs would be of interest to physicians from throughout the state. Could we ask that you take a few moments to fill out the following questionnaire as completely as possible. Your answers will help the council formulate plans for its future activities.

1. Indicate your area of practice: \_\_\_\_\_ Oklahoma City, \_\_\_\_\_ Tulsa, \_\_\_\_\_ Northeast Oklahoma, \_\_\_\_\_ Northwest Oklahoma, \_\_\_\_\_ Southeast Oklahoma, \_\_\_\_\_ Southwest Oklahoma.

2. Indicate your specialty. \_\_\_\_\_

3. How often do you attend a continuing medical education function (once a year, twice a year, etc., etc.)? \_\_\_\_\_

4. Where do you attend such functions (in hospital, in town, at the medical center, in state, out of state)? \_\_\_\_\_

5. Where would you "prefer" to attend such functions? \_\_\_\_\_

6. Have you ever attended a continuing education function limited to socioeconomics or business? \_\_\_\_\_

7. If the topic was of interest to you would you be *more likely* to attend a \_\_\_\_\_ regional seminar or \_\_\_\_\_ statewide seminar?

8. Would you be *more likely* to attend a seminar on \_\_\_\_\_ socioeconomics or \_\_\_\_\_ scientific/medical topics?

9. Please list the medical topics that might be of interest to you. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Please indicate the socioeconomic topics that would be of interest to you:

\_\_\_\_\_ Use of Relative Value Studies in fee structures

- \_\_\_\_\_Procedural Coding
- \_\_\_\_\_Billings and Collections
- \_\_\_\_\_Bookkeeping Procedures
- \_\_\_\_\_Unified Office Records
- \_\_\_\_\_Malpractice Prevention
- \_\_\_\_\_Medicare and Medicaid Payment Problems
- \_\_\_\_\_Medical reports required by law
- \_\_\_\_\_ (Please list others that might be of interest): \_\_\_\_\_

11. Would you send your office personnel to a course on socioeconomics covering some of the topics listed in the question above? \_\_\_\_\_

12. Comments: Please give us the benefit of your thinking on the subject of continuing education for physicians. Your comments, criticisms, and suggestions would be greatly appreciated. \_\_\_\_\_

## Report of the COUNCIL ON PROFESSIONAL AND INTERVOCATIONAL RELATIONS

May 12, 1974  
(APPROVED)

### *Council Members*

Marion C. Wagnon, MD, Chairman  
Norman A. Cotner, MD  
Bryce O. Bliss, MD  
Marvin K. Margo, MD  
Kenneth G. Lowe, MD  
Don F. Rhinehart, MD  
Orby L. Butcher, MD  
Frank W. Clark, MD  
Floyd F. Miller, MD  
Fred W. Sellers, MD  
David P. Mitchell, MD

### SECTION I THE COUNCIL

The Association maintains liaison with various professional organizations and groups in Oklahoma. It is the purpose of this Council to maintain working relationships with these groups when it is in the best interests of all parties, and ameliorate differences when they

occur. Formal committees have been established when the need arises, and in some cases joint committees have been appointed to conduct endeavors of mutual interest. Such is the case with the Medical-Legal Relations Committee and the Medical-Dental Committee. In other situations special efforts have been conducted by ad-hoc groups as was done by the Ophthalmology-Optometry Liaison Committee.

A continuing relationship is maintained with Osteopathy, Pharmacy, Nurses, Physicians Assistants and other medical organizations. But, for the most part these discussions are conducted at the staff level and do not require formal committees.

In addition to the above the Council is responsible for the Association's activities in the area of Cults and Quackery — a frustrating task when the promotion of acupuncturists, hypnotists, chiropractors and weight charlatans are considered.

A brief review of the activities in each of these areas follows:

A. *Claim Men's Liaison Committee* During its 1973 meeting the OSMA House of Delegates authorized the creation of the Claim Men Liaison Committee in order to establish a relationship with the Oklahoma Claim Men Association. Due to a number of intervening problems, the formal liaison was never established. However, staff level communications were arranged. A member of the OSMA Executive Staff met with Mr. Dick Lynn, Chairman of the Medical-Claims Liaison Committee of the Oklahoma Claim Men Association. Tentative plans were worked out for a joint meeting between the two associations sometime during this summer.

The primary purpose of the liaison committee will be to work out a code, policy statement, or guideline for relations between physicians and claim men.

Any such guideline or code will be brought to the OSMA House of Delegates for final adoption.

B. *Cults and Quackery* Since the inclusion of Chiropractic services in the State's Workmen's Compensation program and in the national Medicare Program, the cult of Chiropractic has been expanding. At the time these laws were written there was more evidence condemning Chiropractic than ever before. Legislators ignored empirical, scientific data and yielded to political pressure brought



by a well organized campaign. The fact that these may be "hollow victories" (insurance companies and Medicare cover few services rendered by Chiropractors) is little consolation. The practice of chiropractic has achieved a state of legitimacy equal in law to MD's, DO's and other health care practitioners. Obviously the medical profession cannot forever restrict the practice of Chiropractic in legislative halls (Mississippi became the 49th State to grant state licensure to chiropractors). That is not to say the "towel is tossed" but a new approach is indicated. The most vocal opponents of Chiropractic are those who have been abused, and as a result have become more educated about the practice. The National Council of Senior Citizens, National Association for Retarded Children and the American Rheumatism Association have made strong statements against Chiropractic. To protect their members, they have educated them about the unscientific nature of Chiropractic.

Public education appears to be the best answer. Well informed people will not resort to cultist practices and the Council will concentrate next year in this area.

The newest get well quick "fads" are acupuncture and hypnosis. There are no statutory prohibitions to either practice and recently a front page "testimonial" praising the value of acupuncture (done by a chiropractor) appeared in an Oklahoma City paper. Oriental specialists are touring the U.S. conducting three-day courses and while the Board of Medical Examiners has adopted a statement restricting the use of acupuncture, the Attorney General has ruled there is a "Statutory Void." Thus, apparently, anyone can hold himself out as a practitioner of this healing method.

The Council is concerned about abuses in the area of acupuncture and hypnosis and will work with OSMA's Legislative and Public Relations Committee on programs to restrict the practice and advertise the dangers of these practices. The AMA Council on Cults and Quackery has offered its assistance in conducting a program on these subjects. If funds and time can be allocated the Council may recommend to the Board of Trustees that such a conference be held for both medical and lay people.

*C. Medical-Dental Relations Committee.* In 1970 the officers of the Medical Association and the Dental Association decided that it would be beneficial to both organizations to have a joint liaison committee. Five members from each organization were selected to serve by virtue of the positions they held in their respective organizations. It was felt that the Dental and Medical Associations would have joint interests in education programs, Peer Review, political action, rural medicine, public relations and problems associated with the delivery of health care. During the three year period the committee has had sporadic activity. The dentists have organized DEN-PAC, the Dental school has accepted its first class and they have experienced some of the same problems the Association has in the maldistribution of manpower.

The Committee did not meet last year. However, it is assumed, since 1974 is an election year, that some collaboration will be forthcoming.

*D. Medical-Legal Relations Committee* Your committee has met several times during the past administrative year in preparation for two functions.

On March 22nd and 23rd the Joint Medical-Legal Relations Committee conducted a Medical Seminar for lawyers at the Hilton Inn West in Oklahoma City. The purpose of the seminar was to give lawyers an in-depth exposure to anatomy, physiology, the nervous system, terminology, etc. . . . concentrating on those areas of medicine to which they might be exposed sometime during their legal career.

The secondary, and perhaps most important purpose of the seminar was to improve communications between the medical and legal professions in the state. Your committee has frequently found that lawsuits are filed because of a lack of understanding on the part of the lawyer about medical procedures. In addition, by giving lawyers more information on the practice of medicine, we can help them understand our problems and at the same time help them ask intelligent and pertinent questions.

A total of 64 lawyers attended the two-day course which was taught by eight MDs and one PhD.

The committee is currently considering the sponsorship of a second seminar for lawyers on the subject of Medical Terminology. This would be a one-day course designed to famil-



iarize lawyers with the use and the pronunciation of medical terminology.

The 1974 Medical-Legal Institute has been scheduled for Fountainhead State Lodge on Lake Eufaula for July 18-21.

Registration will start on the afternoon of Thursday, July 18. A presentation on Projected Federal Legislation or some other topic of national concern will be given by a member of Congress.

Friday morning, July 19, will be devoted to presentations on pending Federal Legislation that affect both physicians and lawyers. The presentations will be given by Oklahoma Congressmen and their staff members.

The Friday afternoon session will consist of a report on the "Report of the HEW Secretary's Commission on Medical Malpractice." This in-depth report took nearly a year and a half to complete and it wound up with approximately 70 recommendations for improving the malpractice situation.

Saturday morning's session is tentatively divided into three parts. Approximately two hours will be devoted to the legal aspects of professional standards review organizations (PSROs) and a discussion of what effect this new law might have on the confidentiality of patient records. It will also touch on whether or not the so-called "Norms of Care" might become standards of care in negligence actions.

Industrial Court Judge Tom Gudgel has agreed to give a presentation on workmen's compensation.

Final portion of the Saturday morning session will be a segment devoted to "What to Do When the IRS Comes." An outstanding tax attorney and former agent of the Internal Revenue Service has agreed to make this presentation.

The Joint Committee has long felt that the institute, and all activities of the Joint Committee, should be self sustaining. Therefore a \$40 per person registration will be charged for the institute. Last year's institute completely paid for itself and showed a small profit which was used for seed money for the 1974 Institute. In addition, the committee has a profit from the March 22-23 seminar for lawyers.

One of the primary activities of the Joint Committee is to settle disputes between physicians and attorneys, via the Interprofessional Code. The code itself has been adopted by the OSMA House of Delegates

and the House of Delegates of the Bar Association. The committee constantly monitors the code to make sure that it meets current needs and holds itself ready to assist in settling disputes.

During the past year only two disputes were handled by the committee. Both revolved around the same question, whether or not an attorney should pay a physician for a report that the attorney requested.

In both cases the committee pointed out to the parties involved that the answer to their dilemma was contained in the specific language of the code. In one instance the attorney was directed to pay for the report, in the other the physician was directed to seek payment from the patient.

*E. Nursing.* Last year the American Medical Association and the American Nurse's Association formed a sixteen member Joint Practice Commission to study and enter into joint projects on interdisciplinary education, rural health and urban health. Representatives of OSMA and ONA attended the first National Conference of State Joint Practice Committees to investigate the feasibility of organizing at the state level. A decision has not been reached at this time, although it is the stated goal of the parent organization. OSMA will be one of the co-sponsors of an ONA sponsored program "Nursing Workshops on Evaluation and Documentation of Nursing Care." The two-day session is scheduled at the Center for Continuing Education, Norman, July 22-23.

*F. Occupational Medicine.* Members of this Committee and representatives of organized industry have met on two occasions in the past year to discuss problems of mutual interest. The Federal OSHA Act and Workmen's Compensation are perennial problems for both groups.

Workmen's Compensation premiums totaled 55 million last year; in addition, 14 million in claims were paid by self-insurers. Twenty-nine percent of the sixty-nine million are paid for medical benefits. Thus, industry and medicine have major roles in the administration of this program.

Oklahoma is one of the few states in the nation that retains an adversary system in its industrial claims process. This claimant vs. defendant system places the physician in the middle of the adversary process. If his disability rating is low he is suspected by the



employee-patient; if it is high the employer is suspicious. In an attempt to bring order out of this confusion, the association has recommended an impartial medical panel to review disputed cases or has suggested that physicians' ratings be based on "impairment" rather than disability. Employers prefer the panel on the basis that doctors are a better judge of disability than Industrial Court Judges. Legislation has been introduced in several sessions to formalize the panel idea but has been rejected by the legislature. Another approach to accomplish the same objective might be accomplished by direct communication with the Court; use of the panel will depend upon the willingness of the judges and their confidence in its ability to perform. Also, the committee has explored the idea of using influence to effectuate the appointment of judges. Both avenues will be explored.

There are other areas of Workmen's Compensation that are of common interest. Appropriate on-site medical services, medical literature and special medical clinics for plant personnel were ideas that the representatives selected for further discussion.

OSHA (Occupational Safety and Health Act of 1970) has created major problems for employers, especially in the medical service area. Federal requirements, strictly enforced, could jeopardize some of Oklahoma's small industry. The Committee is considering a regional seminar on the medical aspects of this Act.

G. *Ophthalmology-Optometry*. The past year has seen a substantial increase in activity with organized Optometry. Ophthalmologist members of the Association requested that attempts be made to establish a rapport with Optometrists. D. L. Edwards, Sr., MD, Tulsa, along with representatives of the Association met with officers of the Optometric Association to establish a working relationship. Doctor Edwards had attended a joint MD-DO meeting in Kansas and felt that such an effort was worthwhile.

The meeting was held in early summer and most felt that it was fruitful. There was general discussion of Optometrists being included in Eye Foundation activities and legislative matters. Both groups concluded that future meetings should be held.

In June the Association discovered that the University of Oklahoma, through its College of Pharmacy and The Department of Health Studies and Short Courses and Conferences were sponsoring a course "Pharmacology for Optometrists." Optometrists are prohibited by law from prescribing drugs in Oklahoma and OSMA challenged the propriety of teaching a course of this nature to Optometrists. Inquiries were made of the Optometric Association regarding their intentions to expand their practice Act to include the prescribing of drugs. The answer stated there were no plans to do so this session of the Legislature.

Extensive research was conducted on the ability of Optometrists to prescribe medicine for the eye and their legal right to do so. Several states have considered such legislation; Rhode Island has enacted a law and others are pending in Pennsylvania, Texas and Tennessee. Articles published in national optometric publications indicate there is considerable strife within the group, but the trend is generally expansionistic and Optometrists have set as a goal the securing of rights to prescribe.

Ophthalmologists in Oklahoma are opposed to Optometrists prescribing drugs. Considerable discussion with the Dean of the OU College of Pharmacy elicited an understanding of OSMA's concern and a committee to remove the School of Pharmacy as a sponsor.

In addition to the problem over the course in Pharmacology, the State Board of Optometric Examiners filed a lawsuit in Pottawatomie County against an Optician. The petition, among other things, alleged that the Optician was using an Ophthalmometer which violated the Optometric Practice Act. Conversation between OSMA's Legal Counsel and Counsel for the Optometrists failed to remove that section of the petition even though we respectfully suggested that they do so. The case was found in favor of the Optician but is now on appeal to the Supreme Court. The issue that concerns OSMA is the legal precedent that would be set if the Court ruled that an Optician could not use an Ophthalmometer. OSMA has entered the case *amicus curiae*.

These events, as can be imagined, have severely strained any relationship the Association has with Optometrists; while we have acted in good faith, apparently they will not. The future is difficult to predict, but certainly



there is little reason to believe that relations will improve in the near future.

H. *Osteopathy* Most of the Association's liaison with the OOA has been through the Board of Directors of the Oklahoma Foundation for Peer Review and the Association's Board of Trustees. The section of Public Law 92-603 that required formal peer review organizations also required inclusion of Doctors of Osteopathy in the management process. Several meetings between representatives of OFPR and OOA resulted in general agreement on several major points. OOA supported the single PSRO concept, their attitudes and concern about the potential bad effects of PSRO were the same as OSMA and they agreed that they should share in the financial obligations of OFPR during the investigative period. OFPR recommended that three of the twelve voting seats on the OFPR Board be filled by representatives of OOA. That recommendation was agreeable to organized Osteopathy and affirmed by OSMA Delegates on April 6.

There have been several legislative matters of joint concern to OOA and OSMA. SB 593, HB 1291 and HB 1481 affected both groups adversely. Joint efforts succeeded in killing two of the three and HB 1291 appears to be dead. (See Legislative Committee Report.)

Funding for the new Tulsa School of Osteopathic Medicine is practically assured. The first year class of 36 students has been selected and will begin training this fall. Enrollment will increase to 56 in 1975 and ultimate plans are for approximately 100 students per class. John Borson, EdD, is President and acting Dean of the new school.

I. *Pharmacy* Pharmaceutical manufacturing companies and the State's Pharmacists came under severe attack in the Oklahoma Legislature this session. Bills to require price posting, labeling and substitution were introduced and hotly debated. OSMA's Legislative Committee worked with Pharmacists on some of the bills, all of which failed. Drug substitution legislation (authorizing pharmacists to substitute a generic equivalent) has become a major issue in several states. In some cases Pharmacists want the privilege to substitute and in others (as is the case in Oklahoma) they do not. Physicians should visit with local pharmacists and discuss mutual problems, but should not permit free substitution of drugs. Testing is not suffi-

ciently sophisticated to establish therapeutic equivalency of similar drugs.

Your Council will maintain close liaison with the Pharmacy Association on this important matter.

J. *Physicians' Assistants* The March Issue of OSMA *Journal* contained an article "Current Status of the Physicians' Assistant in Oklahoma." This new program at OUHSC is producing a new health worker that promises to be of great benefit to the physician. Several of the OU graduates are practicing in Oklahoma in various practice arrangements and their performance is being evaluated at this time. Members of the Association are on the PA Advisory Committee to the Board of Medical Examiners and helping with the development of this new program.

There are a few problems as were anticipated. However, the feedback from physicians, employers and preceptees has been good. Each PA spends fourteen months in "on the job" training and ten months in a didactic program. Graduates receive a Bachelor of Health Degree.

Anyone interested in the program should read the March article, or for copies, contact OSMA.

## SECTION II SUMMARY AND RECOMMENDATIONS

This is primarily an informational report to the House of Delegates. However, the reports of the various committees reflect the current attitude of OSMA to its allies and adversaries. If the House wishes the Council to embark upon courses different from those indicated herein, it should so state. Otherwise, the Council would recommend:

1. That its activities be continued;
2. That authority be given to sustain its course in relation to Optometrists; and
3. Approval be given to the conference on Cults and Quackery if it proves to be feasible.

Report of the  
COUNCIL ON PUBLIC POLICY  
May 12, 1974  
(APPROVED)

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Homer D. Hardy, MD, Tulsa  
Jake Jones, Jr, MD, Shawnee



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Gerald L. Beasley, Jr., MD, Duncan  
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Duane E. Brothers, MD, Tulsa  
Eugene S. Bell, MD, Tishomingo

*State Legislative Committee*

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Robert R. Dugan, MD, Oklahoma City  
John R. Smith, MD, Oklahoma City  
Joseph W. Stafford, MD, Enid  
M. Tom Buxton, MD, Oklahoma City  
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Robert S. Ellis, MD, Oklahoma City  
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*Medical Heritage Committee*

George H. Garrison, MD, Oklahoma City,  
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R. Palmer Howard, MD, Oklahoma City, Vice-  
Chairman (& Mrs.)  
William R. Paschal, MD, Oklahoma City (&  
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Neil B. Kimerer, MD, Oklahoma City (& Mrs.)  
Clinton Gallaher, MD, Shawnee (& Mrs.)  
E. C. Mohler, MD, Ponca City (& Mrs.)  
B. E. Blevins, MD, Midwest City (& Mrs.)

**SECTION I**  
**COUNCIL ACTIVITIES**

During the past year, your Council on Public Policy took into its own jurisdiction consideration of such subject areas as Public Re-

lations, PSRO Repeal, Improvement of State Legislative Activities (including interrelationship with the Oklahoma Medical Political Action Committee), and Federal Legislation. The Council's reports on these subjects, together with appropriate recommendations, are presented below:

*A. Public Relations Program:*

Our goal in this area is to re-vitalize existing PR activities and to launch new ones that are within our reach from a financial standpoint.

1. *OSMA Newspaper Health Column:* This column has been prepared by OSMA staff and mailed to weekly newspapers for nearly ten years. It is called "A Message From Your Doctor," and quotes the association on a variety of health education topics. Usage by weekly newspapers has declined from the bonanza of earlier years. The Council has decided to change the format of the column . . . to re-direct it to all *daily* papers (except those in Oklahoma City and Tulsa) and to discontinue sending it to weeklies . . . and to enlist the aid of local physicians in assuring its usage in hometown dailies. The column will appear over the byline of the President of the OSMA (ethics cleared by OSMA Board of Trustees) and it will be written in the style of the popular syndicated columns now used by some papers. Material for the articles is being obtained from local physician-specialists in the various subject areas. The Council on Public Policy feels that these changes, to be implemented in 1974, will result in an outstanding public relations activity.

2. *Media Visitation Program:* A strong effort will be made during the next year to undertake a personal visitation program on a continuing basis with newspaper editors and other media executives across the state. Particular emphasis will be placed on improving rapport with the twenty-five or so leading daily newspapers. OSMA staff and representatives of the Council will endeavor to assess medicine's assets and liabilities in first-hand conversations with leaders of the press, and to identify services which the OSMA could provide to correct public information problems and/or to furnish usable health information to Oklahoma readers of the principal daily newspapers. Our aim will be to identify the needs and interests of newspaper editors, and to respond to them as an authoritative source of health information. The Media Visi-



tation Program could be utilized, as well, to enhance usage of the new health column mentioned in the preceding section.

3. *Television Specials:* Opportunities abound to promote and develop television specials on health subjects in cooperation with the principal TV stations in Oklahoma City and Tulsa. Previous OSMA efforts along this line ("Rub Out Rubella," WKY-TV, Oklahoma City) have been most rewarding, and in the television industry health topics are among the most popular as public service programs. It is the intention of the Council on Public Policy during the next year to inspire and help develop one or more television specials of this nature. Subjects under consideration are: "Rural Health," "Medical Education," "Education for Marriage," "Drug Abuse," and "The Organization of Medical Services and Organized Medicine . . . Issues and Answers."

4. *Speakers Bureau:* For several years the OSMA operated a statewide Speakers Bureau for the benefit of civic groups and service clubs. A team of physician speakers was selected, and the AMA conducted an excellent two-day training program taught by speech specialists who also utilized a video tape recorder. A brochure was sent to all civic and service groups advertising the Speakers Bureau and optional topics available. Speaking opportunities were many, but problems occurred in sustaining the program. Many of the groups requesting speakers were quite small, and statewide invitations exceeded the ability of OSMA speakers to meet all engagements. In short, the magnitude of the undertaking was too ambitious. The Council on Public Policy, however, believes that a modified Speakers Bureau activity should be started. Emphasis will be placed on civic groups and service clubs located in cities of 10,000 population or more . . . a new descriptive folder will be designed . . . new topics will be chosen and sample speeches written . . . and another speakers training program will be carried out either through the services of the AMA or through using local public speaking experts.

5. *OSMA Publications:* The association's newsletter, "OSMA Comment," and the "*Journal of the OSMA*" have been discussed by the Council on Public Policy as highly regarded internal communications media. To enhance readership of the *Journal*, it is suggested by the Council that a "preview page"

in the front of the publication be used to capsule the contents and lead the reader inside to the excellent scientific and news articles. A specific name has not been suggested, since this idea and the name of the page are in the province of the OSMA Editorial Board, but something synonymous with "Periscope" or "Inside This Issue" would seem to be in order.

6. *Use of AMA Material:* The AMA regularly issues excellent press releases and TV spots and programs direct to the media in Oklahoma. However, usage of this public service material is not satisfactory, probably because it comes from a national organization. The Council on Public Policy believes that use of the AMA printed press releases could be enhanced if they were routed through the OSMA . . . the state association could be identified as the source of the story and greater use attained. Also, the AMA should rely more heavily on the OSMA to place its television spots in prime time, and the excellent new AMA Today's Health TV Talk Show should be marketed to state television outlets through the OSMA and/or the appropriate county medical societies.

#### RECOMMENDATIONS:

1. It is recommended that the OSMA Newspaper Health Column be converted for use in *daily* newspapers on a new format as described in this report. The new plan should be underway by July 1, 1974.

2. It is recommended that the Media Visitation Program be undertaken in a thorough manner by the OSMA staff PR Director under the jurisdiction of the Public Relations Committee and the OSMA Executive Director. The program should be planned on a regularly scheduled basis and should be commenced by July 1, 1974.

It is recommended that public service television opportunities be thoroughly exploited by the OSMA staff PR Director under the jurisdiction of the Public Relations Committee and the OSMA Executive Director. Work should begin in the summer of 1974 on at least two such shows.

4. It is recommended that the OSMA Speakers Bureau be reactivated in the summer of 1974 for implementation on or about September 1, 1974 by the OSMA staff PR Director under the jurisdiction of the Public Relations Committee and the OSMA Executive Director. The plan should be as described in this report and should include a speakers training seminar before September 1, 1974.



5. It is suggested to the OSMA Editorial Board that a "preview page" capsuling principal scientific and news articles be regularly featured in the front of the *OSMA Journal*.

6. It is recommended that the Chairman of the Council on Public Policy correspond with the Public Relations Director of the AMA to seek the distribution of AMA press releases through the OSMA and to include the OSMA in efforts to place AMA TV spots and the new Today's Health TV show.

*B. PSRO Repeal Campaign:*

On April 6, 1974, the OSMA House of Delegates authorized the association's Board of Trustees to invoke an assessment on the membership if deemed necessary to carry out a public information program on the Professional Standards Review Organizations law or to bolster Congressional liaison efforts in carrying out the association policy to repeal PSRO.

At the present time, it does not appear that any assessment will be necessary. OSMA efforts to date have achieved repeal commitments from Senator Henry Bellmon, Senator Dewey Bartlett, Representative John (Happy) Camp, Representative Clem McSpadden, Representative John Jarman, Representative Tom Steed and Representative James Jones.

Repeal of PSRO, as far as Oklahoma is concerned, is viable. However, the problem is of a national nature. A recent OSMA poll of state medical associations indicates that 29 state groups are not making any effort to repeal the law, 11 are actively seeking its repeal, 9 did not even respond to our question, and one state reported that it has yet to reach a decision.

This apathy to PSRO (or resignation to the fate of PSRO) could well be attributed to the AMA's confused position on the law, a position which will likely be clarified by the AMA House of Delegates when it meets on June 23-27, 1974 in Chicago.

At the last AMA House of Delegates meeting, an attempt was made to alter the AMA's policy to one of seeking repeal of the law. However, confusion resulted in the final report adopted by the House of Delegates, and it was subsequently interpreted by the AMA Board of Trustees that the Delegates did not instruct the association to undertake a program of repeal. The OSMA wrote to all 1973 Delegates to the AMA in an effort to assess

their "intent" at the last meeting. Of 155 AMA Delegates responding, 87 thought they had adopted a position of repeal while 68 supported the interpretation of the AMA Board of Trustees.

The OSMA will introduce PSRO repeal resolutions at the forthcoming meeting of the AMA House of Delegates.

Meanwhile, there does not seem to be any justification at this time in Oklahoma to launch a massive and expensive public information program on the deleterious effects of PSRO. Seven of the eight members of the Oklahoma Congressional Delegation already support our position, and it would be best for us to lobby the AMA and other state medical associations in an effort to extend the repeal movement on a nationwide basis.

*C. Improvement of State Legislative Activities:*

The Council, at the request of the State Legislative Committee, has considered ways and means to bolster our effectiveness with the Oklahoma Legislature in the face of ever-increasing activities which affect the profession.

As an historical note of interest, the association has come almost full circle over the years in the manner of approaching state legislative issues. For many years, the OSMA effectively dealt with the issues of the times through heavy reliance upon "grassroots" contacts between physicians and the legislators from their areas. The problems were small in number, however, and in time it was felt that a stronger central lobby was needed in order to cope with increasing volume of legislative bills. A new member was added to the OSMA staff who had a primary responsibility to represent the profession in the Oklahoma Legislature. This step proved to be effective in keeping abreast of mushrooming medical bills, but because of its effectiveness it created another problem . . . a decline in physician participation in the legislative affairs of the association. Too many physicians began placing too much reliance in the OSMA staff to successfully handle too many bills.

We have been "out-lobbied" on several important bills in the last year or two. These bills had a common characteristic . . . they were such that a large group of individuals stood to gain financially by their passage, and these individuals turned out in large numbers to visit legislators in their offices



and to stack the galleries at the time of debating and voting. Our lobbyist had done his job . . . but we lost because we failed to produce anything like the grassroots response generated by our opponents. In cases like this, the merits of the issue are often disregarded in the face of political pressure.

Thus, today, we are out of balance in our approach to key legislative efforts. We need the employee to assess the political intrigue of the Oklahoma Legislature on a daily basis . . . we need the personal friendships he can acquire and the strategies he can determine . . . but when it comes to a key piece of legislation where we have attracted a vigorous and hungry opponent, our lobbyist needs a demonstration of political strength from physicians throughout the state. The bills we have lost in the Oklahoma Legislature were not lost because we did not have enough lobbyists . . . they were lost because we could not or did not motivate a massive response to these issues from our membership.

A grassroots campaign is not needed on all issues; most can be quietly and effectively handled by our lobbyist and the OSMA committee. But there are two to six major bills a year which demand an ability to produce a rapid and large-scale show of strength.

This technique has been employed during the 1974 session quite effectively. By large scale mailings to the membership, Senate Bill 593 was defeated despite vigorous support from labor and the plaintiff's bar. Through the use of telephone communications to physicians throughout the state, we now have the votes to block House Bill 1291 in the Senate. These bills, if adopted, would either breed additional malpractice suits against physicians or would compromise successful defense. There is no real way to assess the value of their defeat, but it is accurate to state that we have staved off additional malpractice claims and defense costs of great magnitude. We can expect to see these bills introduced again year after year . . . we can continue to win year after year . . . but we can lose only once.

In short, to be effective today we need a lobbyist at the State Legislature who is supported enthusiastically by the membership when needed. Communicating with the membership, especially on short notice, is expensive . . . and we need to take advantage of the most modern communications tools.

The State Legislative Program needs addi-

tional support, but the degree of this support must be kept in balance with other association activities of equal importance.

#### **RECOMMENDATIONS:**

1. It is recommended that the OSMA maintain its present lobbying level in terms of one full-time staff member having this assignment as a principal duty.

2. It is recommended that additional financial support, as determined by the OSMA Board of Trustees, be allocated to the State Legislative Committee for the primary purpose of defraying postage for large-scale mailings to the membership on key issues.

3. It is recommended that the Board of Trustees purchase or lease an automatic typewriter in the immediate future for the purpose of speed and quality in communicating with legislators, both state and national, and for many other uses of value to the total activities of the OSMA.

4. It is recommended that the Board of Trustees, if feasible from a cost standpoint, install a WATTS line at OSMA headquarters to facilitate rapid communications with the profession on legislative issues of a state and national nature.

5. It is recommended that all readers of this report lend their full support to the Oklahoma Medical Political Action Committee because of its interrelationship with a successful legislative program.

#### **D. Federal Legislation:**

Of principal concern to physicians is the major push which has developed in the US Congress over the issue of National Health Insurance.

Inflation has hit hardest at the cost of labor, and hospitals are uniquely personal service institutions which cannot materially offset rising labor costs through automation. Thus, the costs of inpatient health care have been spiraling far higher than general inflation rates. The result is that a new group of medical indigents — numbering some 20 million persons — has been created. These are the "working poor" . . . those who do not qualify for Medicare or Medicaid because of age or their modest earnings, but who because of the nature of their employment or their low incomes are unable to purchase quality health insurance.

This set of circumstances, plus national concern over the costs of catastrophic illness, have added impetus to the long-standing threat of National Health Insurance. There



are more than 20 proposals for NHI now pending in Congress. Arguments are over the form it should take rather than whether or not it is needed . . . there is literally no member of Congress that we know of who is arguing against the principle of NHI.

Three bills have emerged as contenders for early consideration by the Congress. These are summarized briefly below.

*A. Long-Ribicoff Bill:* Senator Russell Long is Chairman of the powerful Senate Finance Committee, and Senator Ribicoff is a former Secretary of the Department of Health, Education and Welfare.

There are three parts to the bill:

Title I would establish catastrophic health insurance for all Americans financed through Social Security taxes. Benefits would begin after an individual is hospitalized for 60 days or has incurred other medical expenses in excess of \$2,000. Once coverage begins, there is 20% co-insurance on additional medical bills and an annual hospital deductible amounting to one-fourth of the Medicare deductible.

Title II would expand Medicaid to cover a total of 34 million persons, 12 million of whom would be new additions . . . the "working poor." The new Medicaid program benefits would be tailored to meet the deductibles of the catastrophic coverage, Title I (60 hospital days or \$2,000 medical costs).

Title III makes basic coverage (60 hospital days or \$2,000 medical costs) available to self-reliant citizens at their own expense or through employer fringe benefit programs.

The Long-Ribicoff Bill is expected to cost \$8.9 billion a year.

*B. The Nixon Administration Bill:* Called the "Comprehensive Health Insurance Plan" or "CHIP," the Administration's NHI plan is being pushed with vigor.

Under this plan, Americans would be grouped into three categories for the provision of standardized basic benefits, and *all* would receive catastrophic benefits.

In the first category, the "Employee Health Insurance Plan" would cover all families with incomes above \$7,500 annually. Employers would be required to offer all employees the basic coverage and to pay 75% of the premium costs. There would be deductibles and co-insurance to help control utilization. There would be a maximum out-of-pocket cost per family of \$1,500 a year before the catastro-

phic program would take over.

In the second group, the "Assisted Health Insurance Plan," states would contract with the federal government to provide basic benefits to families with less than \$7,500 annual income. Premiums, deductibles and co-insurance would be scaled to income. Working families with incomes up to \$5,000, for instance, would pay no premiums at all. Deductibles and co-insurance for \$7,500/year families could not extend \$1,050 per year before the catastrophic benefits would begin, and lower income families would pay even less toward the costs of basic services.

The third category would be Medicare patients. Medicare benefits would be upgraded to the same levels as the basic benefits offered under the Employee Program and the Assisted Health Insurance Plan.

As stated above, no American family would be out more than \$1,500 per year in personal expenses (deductibles and co-insurance for covered services) before the limitless catastrophic benefits would begin. Over-65 beneficiaries would have a maximum personal liability of only \$750 a year under the basic program. Low income people under the Assisted Health Insurance Plan could have maximum annual liabilities as little as \$105.

Benefits under the Administration NHI plan would include unlimited hospitalization, unlimited physicians services, outpatient drugs, mental health services, preventive medical and routine dental services for children, prenatal and family planning services, home health services, blood and blood products, and post-hospital extended care.

The program would place emphasis on Health Maintenance Organizations; physicians compensation would be regulated at the state level; and the PSRO law would be utilized for cost and quality control.

The Department of HEW estimates that only \$5.9 billion in new federal funding would be needed each year, plus about \$1.0 billion in state participation. However, when the cost of the program imposed on the nation's employers is considered, the Nixon Administration Plan would cost about \$40 billion annually.

*C. Kennedy-Mills Bill:*

Congressman Wilbur Mills is Chairman of the House Ways and Means Committee and Senator Edward Kennedy is Chairman of the Senate Health Committee. This bill is sponsored by organized labor and has strong lib-



eral support.

The scope of benefits is virtually identical to the Nixon Bill and there would be a \$150 per year individual deductible and 25% co-insurance on covered services (except for certain low-income individuals and families). There would be no further co-insurance or deductibles after a family expended \$1,000 in a year.

The Kennedy-Mills plan would be totally financed and administered through the Social Security Administration (where the Nixon Bill would primarily use the private insurance industry).

Physicians would be paid according to a negotiated fee schedule developed on a regional basis. They would send their bills to Social Security, and would be paid the entire amount, after which SSA would collect the deductibles and co-insurance from the patients. Drugs would be controlled by a federal formulary, and there would be a \$1.00 charge to the patient for each prescription filled.

The program would absorb the Medicaid program, and Medicare would be changed to offer a voluntary program for long-term care benefits (\$3.00 a month contribution required).

PSRO would again be utilized, and a Health Resources Development Board would be created to continually promote health resources planning, to promote quality of health care, to compare costs and quality of various health care delivery systems, to study different methods of payment, to assist in the establishment and operation of HMO's and to analyze the effects of health education and preventive health services. State Health Planning Agencies would be given greater federal authority.

The program would be financed by new Social Security taxes and an increase in the taxable wage base to \$20,000 a year.

The program is expected to cost more than \$40 billion a year.

*Comment:*

The long-awaited battle lines for National Health Insurance seem to be drawn . . . more than 20 proposals have now been sifted down to three principal bills. At the present time, the issue primarily centers between the Nixon plan and the Kennedy-Mills plan, but Senators Long and Ribicoff have the potential of generating tremendous support for their less-expensive, less-disruptive program.

The AMA Medcredit Bill, despite 182

Congressional sponsors, seems to have been disregarded by the nation's most powerful politicians.

It is expected that the American Medical Association's Council on Legislative Activities will have an important report to make to the AMA House of Delegates in June on this critical subject. Like the PSRO issue, organized medicine needs to have a national policy on NHI which can be supported in all jurisdictions. If we become divided, we will have little to say about the conditions under which we will practice in the future.

## SECTION II STATE LEGISLATIVE COMMITTEE

At the writing of this report, the flag has yet to drape the legislative clock. Adjournment "sine die," which appeared imminent a few days ago is speculative today. A special House Investigating Committee, and an insolvable University Hospital deficit are the latest Legislative crises. Election year politics have not changed, and while most legislators would like to go home, none want to leave the State Capitol without re-election "sticks" or "carrots."

Medical legislation during the 34th Legislature (1st and 2nd sessions) has continued its trend of occupying more of our lawmakers' time. This Committee has reviewed over ninety bills during that two year period—proposals that cover subjects from abortion to workmen's compensation. We have seen the legislature avoid the subject of acupuncture while they debated the approval of Monrone chrysops (sand bass) as the official state fish. We have observed a continuing reluctance to finance the operating expenses of the state's only public funded general hospital while they (the lawmakers) concur in the appropriation of millions for the financing of new training programs for physicians. A proposal to simplify claims for health insurance benefits has been rejected while a proposal to study the advisability of regulating health facilities ". . . in order to provide efficient low-cost health care and medical services . . ." has passed.

These are but a few of the many measures that are proposed to deal with health care problems in Oklahoma. Lawmakers, though many times well meaning, have introduced a plethora of bills that oftentimes create more problems than they solve. We have attempted to keep the legislature advised of the attitude of doctors on medical legislation. Likewise we have tried to keep you informed of measures that can affect your



practice, your patients' health—your way of life. In some cases we have been successful.

Senate Bill 593—a bill that would have made you extremely vulnerable to malpractice suits—was defeated because of your efforts. On the other hand, House Bill 1022 a measure that gave an injured worker covered by Workmen's Compensation Insurance the right to choose his own physician, including a chiropractor—was enacted into law.

The success or failure of a proposed bill is not always decided on its ultimate benefit to the majority. To say that legislation has vested interests is a gross understatement. *Every* bill is sponsored by special interests — be it the legislator himself, farmers, organized labor or organized medicine. Every bill has a constituency — and most have both pro and con. Statutory insertion is the result of one group winning and one group losing, and as is almost always the case, the strongest group prevails.

Physicians can have a strong influence on the legislature — That is fact. Only 2 of 23 bills opposed during the past two years have been signed into law. Strongest efforts have been expended when there was a threat of additional malpractice burden, as was the case with House Bill 1291 and Senate Bill 593. We need to secure the same kind of support for programs that hold less direct benefit now, but have far-reaching import for the future. Examples are: adequate support for our Health Sciences Center; Board of Examiners control over the practice of acupuncture; a curtailment of the expansion of cultist practices; an adequately staffed and funded emergency medical services system; health education in our public school system and incentives to encourage the rebuilding of depleted health resources in rural Oklahoma. Some of these programs are in progress, others await medical community influence.

The Committee has experienced the euphoria of victory and the despair of defeat. We have examined our weaknesses and exploited our strength. We have done our best. The following are ideas that we think will improve the effectiveness of the Association legislative program.

*Improved Communications.* Timing is critical when lobbying a bill. Contact with the profession or with the legislature must be quick, accurate and professional. Currently the association uses an outdated mimeograph for mass production of letters — the quality is not consistent with the audience. It is not complimentary to the association to send to the State Capitol let-

ters that do not reflect the character of the association membership. Moreover, busy physicians who receive large quantities of mail can hardly be asked to respond promptly to letters that are of less class than those selling lots in Arkansas.

We have suggested and the Council has recommended that the Board of Trustees approve expenditures for an automatic typewriter.

*Improved Liaison with Medical Specialty Organizations.* Almost every session of the legislature bills are introduced that are of primary interest to a specialty organization. The Committee has been expanded to try and accommodate those most frequently affected. However, we still need expertise. We have always felt a matter concerning Ophthalmology is a matter of concern for all physicians, but it is important that specialty organizations be especially alerted when legislation directed at their practice is introduced. To assist us in this liaison, we will ask each specialty society to offer to the Committee the names of three or four advisors who are representative of their organization.

*Doctors' Wives Day at the Legislature.* Every two years the Association has assisted the Auxiliary in conducting an informative session on politics at the State Capitol. Attendance has run from sparse to overwhelming. The consensus is that these sessions are educational, but do not begin to utilize the full resources of the women's auxiliary. We are convinced that knowledgeable, concerned and active doctors' wives can be one of our biggest assets. We plan to work closely with the auxiliary next year and at future legislative programs to include their husbands.

*Legislative Doctor of the Day.* This has been and is one of the best public relations efforts of the association. Both physicians and legislators enjoy the opportunity to visit at the Capitol and exchange views. In addition, we render an invaluable service to lawmakers and capitol employees.

This year, at the request of the Legislative leadership, Osteopathic physicians provided coverage during the month of February. There were no unusual problems and it is assumed that similar arrangements will be made next session. One legislator has requested the opportunity to invite his physician to serve, and we see no objection to this arrangement. We will, however, fully review the program before changes are made. We would like to express our gratitude to the physicians who served and suggest to those who have not to avail themselves of



this opportunity.

*Legislative Liaison Committee.* One of the committee's most effective lobbying assets is the direct efforts of physicians who know legislators personally. The committee solicits the aid of this special group and publishes for their benefit a weekly "Legislative Reporter." We have been criticized because there are physicians who have close relationships with their elected officials that are not on our mailing list. We apologize — any member of the association who wants to receive our report is welcome. We need help. Many times the course of a bill in the legislative process is changed by one vote and the more activists we have on our side the better. If any physician knows a Representative or Senator personally, and is willing to contact him when the need arises, we would appreciate his volunteering for this responsibility.

*Telephone Communications.* When House Bill 1291 was reported out of the Senate Committee we started a telephone campaign to physicians across the state. In a period of about six working hours we had contacted approximately 50 doctors who agreed to call their Senator. The results were 28 committed votes, almost certain defeat for the bill. The results were great, the cost high. We think that a WATTS

line would improve our direct communications and have requested authority to investigate its use.

SUMMARY

The most important influence on the legislature is a constituent, a voter who knows his elected official, knows his problems, and knows when and how to talk to him. Preferably, the voter-constituent should be a campaign worker and financial supporter. Finally, the voter, constituent, campaign worker-financial supporter must be informed about the issues. When we have 2,300 members who are informed about medical issues, who actively seek out candidates, help finance campaigns, then we will have no legislative problems.

*Recommendation #1.* We recommend that the activities of the Committee be continued.

*Recommendation #2.* We recommend that the House of Delegates concur in the suggestions and recommendations of this report.

Attached is an Overview of the medical bills introduced during the 34th session, our position on each and its legislative disposition. Copies of the bills are available at OSMA headquarters on request.

OVERVIEW OF MEDICAL BILLS INTRODUCED  
IN THE 34TH OKLAHOMA LEGISLATURE

Number of Bills Reviewed .....	93
* Bills Supported	27
**Bills Opposed	23
No Position	43
* 14 Passed	** 2 passed
9 Failed	20 Failed
4 Pending Action	1 Pending Action

		Position	Outcome
ABORTION			
SB-139	Uniform Abortion Act	N	Dead
HB-1295	Authorizing abortions	N	Dead
HB-1448	Removing from the Medical Practice Act abortions as a crime	N	Dead
ACUPUNCTURE			
HB-1340	Authorizing limited practice of acupuncture	F	Dead
BOARD OF HEALTH			
SB-267	Changing composition of the State Board of Health	A	Dead
SB-299	Establishing license fee for emergency vehicles	F	Enacted
HB-1316	Changing composition of State Board of Health	A	Dead
BOARD OF MEDICAL EXAMINERS			
SB-111	Financial disclosure	A	Dead
SB-221	Repeal of Basic Science Act	F	Enacted
SB-326	Granting Board of Medical Examiners authority to promulgate rules and regulations regarding the practice of prenatal and postnatal care.	N	Dead
SB-406	Mandatory deposit of funds	A	Dead
SB-525	Provides for FLEX Examinations	F	Enacted



SB-699	Providing for the confiscation of equipment used in the illegal practice in a branch of the healing arts.	A	Dead
SB-724	Provides for the certification of various paramedics	A	Dead
HB-1142	Sick Doctor Act	F	Enacted
HB-1198	Provides for FLEX examinations	*F	Dead
HB-1474	Financial Disclosure	A	Dead
HB-1575	Requiring financial disclosure	N	Dead
*Enacted 2nd Session as SB-525			
<i>BOARD OF UNEXPLAINED DEATHS</i>			
SB-002	Provides for an inquest	F	Dead
SB-55	Appropriation to Board of Unexplained Deaths	F	Enacted
HB-1427	Medical Examiner records	F	Open
<i>EMERGENCY MEDICAL SERVICE</i>			
HB-1510	Establishing Advisory Council on emergency Medical Services	N	Dead
HB-1734	Establishing rural ambulance districts	F	Enacted
HB-1745	Authorizing County Commissioners to contract for ambulance services	F	Open
<i>HEALTH EDUCATION</i>			
SCR 98	Health Education in Public Schools	F	Enacted
HB-1128	County levy for health services	N	Enacted
<i>HEALTH PLANNING</i>			
SB-213	Establishing a State Health Planning Agency	N	Open
SB-47	Establishing a Health Planning Commission	N	Enacted
<i>HEALTH INSURANCE</i>			
HB-1173	Uniform Claim Form	F	Dead
<i>HOSPITALS</i>			
SB-114	Appeal procedure for aggrieved physicians	A	Dead
SB-245	Compulsory admission for patients	N	Open
<i>INDIGENT CARE</i>			
SB-389	Waiver of privilege to medical records	A	Dead
SB-390	Waiver of privilege to medical records	A	Dead
HB-1091	Authorizing DISRS to purchase prescription drugs	N	Dead
HB-1194	Authorizing DISRS to purchase prescription drugs	N	Dead
<i>MALPRACTICE</i>			
SB-138	Contributory negligence	A	Amended & Enacted
SB-244	Expands workmen's comp. to physician	A	Dead
SB-579	Advance authority for medical treatment	F	Open
SB-593	Expands workmen's comp. to physician	A	Dead
HB-1207	Providing for admission of certain kinds of evidence	A	Dead
<i>MEDICAL SCHOOL</i>			
SB-77	Provides for Trust financing	N	Enacted
SB-115	Providing for the handling of the state funds	N	Enacted
SB-163	Appropriation to Higher Regents	N	Open
SB-316	Transferring Children's Hospital	N	Enacted
SB-325	Transferring University Hospital	N	Enacted
SB-374	Higher Education appropriation	N	Enacted
SB-526	OUHSC Planning Commission	N	Enacted
SR-9	University Hospital Management Study	N	Enacted
HB-1049	Appropriation to Higher Education	F	Enacted
<i>MENTAL HEALTH</i>			
SB-629	Licensing alcoholic treatment facilities	N	Open
HB-1378	Providing for admission of mentally ill	N	Dead
HB-1398	Providing for the admission of mentally ill	N	Enacted
<i>MISCELLANEOUS</i>			
SB-320	Providing a penalty for the use of various intoxicants	N	Enacted



SB-366	Providing for medical reports in school injuries	N	Enacted
<i>NURSE EDUCATION</i>			
HB-1296	Standards for school nurses	N	Enacted
HB-1650	Nurses loan and scholarship fund	N	Open
<i>PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS</i>			
HCR-1105	Requesting repeal of PSRO	F	Open
<i>PARAMEDICAL PROFESSIONS</i>			
SB-95	Licensing Social Workers	N	Dead
SB-227	Licensing Speech Pathologists and Audiologists	F	Enacted
HB-1011	Licensed athletic trainers	N	Dead
HB-1014	Permitting use of unlicensed nurses	A	Dead
HB-1376	Licensing Hearing Aid Dealers	F	Enacted
<i>PHARMACY</i>			
SB-209	Authorizing DISRS to pay for prescription drugs	N	Dead
SB-309	Pharmacists Education Act	N	Enacted
SB-363	Procedure for retailing hypodermic syringes	F	Dead
SB-603	Clarifying ownership of prescriptions	F	Enacted
HB-1092	Exempting drugs from sales tax	F	Dead
HB-1094	Exempting drugs from sales tax	F	Dead
HB-1205	Providing for the retailing of prescription medicines	N	Enacted
HB-1387	Requiring the labeling of prescription drugs	F	Enacted
HB-1481	Permitting Drug Substitution	A	Dead
HB-1667	Requiring list of certain drugs	N	Dead
HB-1703	Drug Labeling	F	Dead
<i>PUBLIC HEALTH</i>			
HB-1020	Contraceptives for minors	N	Dead
HB-1028	Providing for revocation of drivers license on DWI	F	Dead
HB-1201	Appropriation to Community Health Center in Tulsa	N	Dead
HB-1286	Appropriation for Sickel Cell testing	N	Dead
HB-1336	Providing for employment of school health aides	N	Open
HB-1477	Handling of death certificates	A	Open
HB-1630	Appropriation for Sickel Cell testing	N	Open
<i>RAPE EXAMINATIONS</i>			
HB-1390	Requiring rape examinations	A	Dead
<i>RURAL HEALTH AND MEDICINE</i>			
SB-433	Appropriation for rural medical scholarships	F	Enacted
HB-1058	Appropriation for rural medical scholarships	F	Enacted
<i>SCHOOL OF OSTEOPATHY</i>			
SB-431	Appropriation 1.7 million dollars to Osteopathic School	N	Dead
SB-78	Appropriation to School of Osteopathy	N	Enacted
<i>WORKMEN'S COMPENSATION</i>			
HB-1022	Free choice of physician	A	Enacted
HB-1032	Expanding workmen's compensation liability to physicians	A	Dead
HB-1188	Free choice of physician	A	Dead
HB-1375	Changing contributory negligence	A	Dead
HB-1580	Requiring the furnishing of medical reports	N	Dead

SECTION III

MEDICAL HERITAGE COMMITTEE

While your committee has not been very active during the past year, it has accomplished a few "housekeeping" chores.

One of the recommendations made in the 1973 report of the committee was that it be directed by the House of Delegates to enter into

liaison on medical heritage with the Oklahoma Pharmaceutical Association, the Oklahoma Dental Association, the Oklahoma Nurses Association, the Oklahoma Hospital Association, and the Oklahoma Veterinarians Association.

Each of these organizations was contacted and asked if they would like to enter into such a liaison. All of them responded favorably and the name or names of contacts were supplied to the



OSMA Medical Heritage Committee for use whenever needed.

The 1973 House of Delegates also directed your committee to institute a limited search for the location of medical heritage material. This was done by contacting, via letter, all officers, trustees, members of the House of Delegates, county society presidents and secretaries and requesting their assistance. In the letter to these officials it was stated, "the committee is attempting to locate and acquire medical heritage material. Specifically we are seeking early photographs, manuscripts, office records, newspaper stories and even personal accounts of early day happenings. We are also interested in acquiring *early* medical instruments.

"If you know the location of any such material or if you have any such material that you would like to turn over to the committee for preservation, please let us hear from you. All material that we receive will be kept in trust by your association and used for public displays and historical research."

This letter produced a few leads on the location of historical material. (If anyone reading this report has knowledge of the location of such historical material, the committee would appreciate hearing from you.)

Preliminary contact has been made with the National Cowboy Hall of Fame regarding the possibility of displaying some early day medical artifacts. There is reconstructed on the first floor of the Hall an early day western town. The town includes a doctor's office that would be an appropriate place for such a display.

While the Hall of Fame is not in a position to accept the material for display at this time, it is interested. As soon as the doctor's office display is rearranged, your committee will be contacted for material to be loaned.

Other display locations have also been contacted, such as the Oklahoma Arts and Sciences Foundation and the Historical Society. However, most of these other organizations would prefer to have photographs, as opposed to artifacts. While your committee has collected a great amount of material, there are very few photographs included.

Anyone having knowledge of the location of early photographs of doctor's offices, hospitals, or medical personnel are encouraged to contact the committee.

As leads to the location of medical artifacts and other materials are made known to the committee, your committee intends to work

with the local county woman's auxiliary to assist in locating and procuring the various materials.

Report of the  
FINANCIAL AID TO  
EDUCATION COMMITTEE  
May 12, 1974  
(APPROVED)

*Committee Members*

Ed L. Calhoon, MD, Beaver, Chairman  
Lucien M. Pascucci, MD, Tulsa  
Stanley R. McCampbell, MD, Oklahoma City  
C. Riley Strong, MD, El Reno  
Jack L. Richardson, MD, Tulsa

and

THE FOUNDATION FOR  
COMMUNITY MEDICAL CARE

*Board of Directors*

Ed L. Calhoon, MD, Beaver, Chairman  
Lucien M. Pascucci, MD, Tulsa  
Stanley R. McCampbell, MD, Oklahoma City  
C. Riley Strong, MD, El Reno  
Jack L. Richardson, MD, Tulsa  
Mr. Lloyd R. Barby, Beaver  
Mr. Archibald Edwards, Oklahoma City  
Mr. J. M. Rector, II, El Reno  
Mr. Guy Swadley, Jr., Eufaula  
Mr. William Wise, Idabel

For the past several years, OSMA's financial aid to students has been handled by the Oklahoma Foundation for Community Medical Care. The House of Delegates decided that the major thrust of the student aid program should be directed at encouraging young men to practice in rural and needy areas of the State.

In the late '50's the Association established its loan and scholarship fund to aid medical students. The dues of the association were raised in order that \$5.00 from each dues paying member could be put into the fund. As you can see, with the 2,000 dues paying members, the Association now has about \$10,000 per year to be used for this purpose. Until 1970, the money was used for grants and small scholarships and loans. Since 1970, it has been transferred to the Foundation for Community Medical Care and used to finance the rural scholarship program. Each year the Board of Directors of the loan and scholarship fund meet to officially discuss and



transfer the money to Oklahoma Foundation for Community Medical Care's Board.

OFCMC's Board of Directors is made up of the President and four immediate past presidents of the Association and five lay members. Each year they review the applications and interview students who desire an OFCMC scholarship. Eight young men have been recipients of these funds; two have completed their medical education and are now in residency programs. Over \$57,000 has been invested in future physicians through this program.

Last year the Foundation solicited the assistance of various communities throughout the State, that indicated a need for physicians, in financing students who were interested in the program. Perry, Oklahoma, has organized a Foundation and is financing one/half (½) of the scholarship for John Sayre, MS III, who has agreed to practice there when he completes his training. Frederick has made similar arrangements with John Ferguson, MS III. Thus, the Foundation has expanded its program by using Community funds and hopefully will continue to attract outside monies as the program receives greater acceptance.

The Foundation still receives more applications from students than it can finance. If any member of the House of Delegates knows of a community that wishes to participate, comments should be directed to OSMA headquarters.

Again, this year the Oklahoma Legislature has continued to support the Rural Medical Loan and Scholarship Fund established several years ago. \$100,000 has been appropriated by the 2nd Session of the 34th Legislature. Since 1970 (including the '74 appropriations) the State has spent \$350,000 for rural medical scholarships. Twenty-seven students have participated in the program; three have graduated, one of whom recently established practice in Warner, Oklahoma. The combination of State Government and organized medicine is making progress to bolster our depleted medical manpower in rural Oklahoma.

Next year the Foundation hopes to have enough funds to finance at least one additional student and if other financial resources become available, we will perhaps be able to start even more.

Report of the  
MEDICAL CENTER LIAISON  
COMMITTEE  
May 12, 1974  
(APPROVED AS AMENDED)

*Committee Members*

Howard P. Mauldin, MD, Chairman, Oklahoma City  
C. S. Lewis, MD, Tulsa  
Oliver H. Patterson, MD, Sapulpa  
Robert S. Ellis, MD, Oklahoma City  
Billy Dale Dotter, MD, Okeene  
Jack Parrish, MD, Seminole  
James W. Murphree, MD, Ponca City  
Leonard P. Eliel, MD, Oklahoma City  
C. Rainey Williams, MD, Oklahoma City  
Wendell L. Smith, MD, Tulsa  
M. Boyd Shook, MD, Oklahoma City  
Earl M. Bricker, MD, Oklahoma City  
James P. Jobe, MD, El Reno

*SECTION I  
INTRODUCTION*

The writers of the Association's Constitution and By-Laws established this Committee for the express purpose of "... necessary liaison with the University of Oklahoma College of Medicine and with the Board of Regents of the University of Oklahoma." No educational institution, in recent memory, has been besieged with the number and complexity of problems as has our Health Sciences Center. A vision that inspired Oklahomans to tax themselves \$100 million in the late 60's less than ten years ago, appears to be crumbling in the 70's to the point that the entire medical education program of the State is in jeopardy.

For the past two years the Center's administration and faculty have undergone inquiry after inquiry. Facilities and programs that were the result of good medical education and planning have been severed and placed under separate governing boards. An institution that thrived on compatible interrelationships has been divided. Vested interests have become more important than the interests of all—confusion reigns.

During the past three years the Association (through this committee) has attempted to strengthen its relationship with OUHSC and in some areas, as will be shown in the rest of this report, we have made significant progress. However, the Medical School and its environs are properties of the University of Oklahoma and as such have a basic responsibility to the parent institution.

The Association cannot interject itself into matters that are not within its jurisdiction, and the University cannot transfer its legislated obligation. Thus, while many times, throughout



the vexing tribulations of the past two years, Association leaders have longed for a leadership role in medical center affairs — that role could not be assumed.

The future of the Center is very uncertain now. Legislative leaders apparently are not willing to finance University Hospital at a level sufficient to maintain financial integrity. In fact, Hospital Trustees contend that the proposed \$6.8 million will fund the facility for only eight months. Without University, the school could lose its accreditation. The ramifications are disastrous.

The dilemma facing the Association is that at a time when the Medical School needs more help than at any time in its history, it has been impossible to find a role in which it can be of major assistance.

The transition from a Medical School to a Health Center Campus is partially to blame for the current status of OSMA's liaison. As the center grew the tasks of the chief executive became more management oriented. The Dean of the College of Medicine could not be both a teacher of future physicians and administrator of such a complex consortium of health schools. Thus, the office of Executive Vice President was created. Three physicians and a dentist (William Brown, DDS, current acting Provost) have served as managing officers of the Center and a search is being conducted at this time for a successor to Doctor Brown who wants to be relieved of this duty in order to devote his time to the new dental school. Last year the Legislature separated University and Children's Hospitals from OU control and created new governances for each. In addition, there is an ever-increasing trend toward more control over Medical Center affairs by President Sharp and the OU Regents.

Due to these fluctuating events, and the changing character of the Center's management, the Association must re-orient its liaison efforts. Obviously, if we are to be instrumental in the growth of the Medical Center, we need approval of the OU Regents and Doctor Paul Sharp. Too, by virtue of its critical relationship to the College of Medicine we must develop rapport with the Trustees of University Hospital.

The Committee suggests that as soon as possible the President of OSMA and the chairman of this committee, host a meeting between President Sharp, Dean Robert Bird, Robert Mitchell, MD, (OU Regent), Don O'Donoghue, MD (Chairman University Hospital Board of Trustees) and others the President might select, to

discuss OSMA's liaison with the Health Sciences Center, and develop an appropriate role for this committee.

## SECTION II MEDICAL SCHOOL LIAISON

Annually the association asks its members to voluntarily contribute \$10.00 each for use by the Associate Dean of Student Affairs to assist medical students. The first year the solicitation produced over \$3,000 and last year over \$5,000. The 1974 request will be made this summer. There have been federal matching monies available on a 9 to 1 ratio, thus, Oklahoma doctors are responsible for almost \$80,000 in medical student assistance funds. The great majority of these dollars have been used for loans that will be repaid at low interest rates. If the program continues a substantial loan fund will be perpetuated.

For several years the association has requested more representation on the Admissions Board. Two years ago the admissions procedure and board was revised and now there are fifteen physicians from the private sector, three from the OSMA and three from the Oklahoma Academy of Family Physicians. The remainder of the admissions committee are from full and part time faculty. In addition, the Admissions Committee has fourteen full-time faculty members and nine senior medical students.

The freshman class for 1975 has been chosen. Medical school enrollment has almost doubled in the past five years and the 1975 starting class will have 156 students. Of these, 147 are Oklahoma youngsters.

Last year this committee requested that a study be conducted to ascertain the practice habits of female graduates of the OU medical school. A copy of the study is attached to this report.

The Tulsa branch of the Medical School will open this fall. Martin Fitzpatrick, MD, has accepted the position as Dean. The school, authorized by the legislature in 1972 will offer clinical training to junior and senior medical students. Seventeen will begin this year, with student enrollment eventually reaching 100 by 1978. Students will rotate through Tulsa area hospitals which have been organized under theegis of the Tulsa Medical Education Foundation. There are 58 interns and residents completing training in Tulsa and also 34 juniors and seniors who are taking electives there. Tulsa physicians are contributing approximately 48,000 teaching hours per year to the



education program. The Medical School budget for the Tulsa program will be about \$560,000.

SECTION III  
MEDICAL STUDENT LIAISON

The committee maintains contact with medical students in several ways. For several years we have assisted in locating summer jobs for students who want to work between semesters. This program while continuing, has been the victim of federal price freezes and inflation. The major employer of students in previous years has been hospitals. Because of the price freeze there have been few openings in hospitals this summer. In addition, school curriculum changes do not leave much time for summer employment. Perhaps as economic conditions improve more jobs will be available. Those interested in employing students should contact OSMA headquarters.

There was considerable controversy last fall about the new school policy requiring passage of parts of the National Board Examination for advancement to the next year. The first round of examinations resulted in a high failure rate, leading some physicians and students to feel the examination was unfair. The committee chairman has visited with school officials and found the Oklahoma results are about the same as the national average, and that no action by this committee was required.

The Association Bylaws have been changed to permit special membership for medical students. However, county medical society bylaws will have to be changed before they can actually become members.

SAMA officials frequently contact OSMA for assistance in various activities. We have provided funds and sponsors for SAMA meetings. The committee feels it is important to involve medical students in the activities of organized medicine as soon as possible and practical.

SECTION IV

SUMMARY OF RECOMMENDATIONS

The current financial conditions at the Medical Center preclude the quality liaison this committee should have with Center officials and students. There is constant concern by all connected with OU Health Sciences Center and until its future is more predictable that concern will continue. The overriding issue there is restoration of the financial integrity of the Center complex. Hopefully, when that is accomplished

educational programs can be bolstered and respect for our major health institution restored.  
*RECOMMENDATIONS:*

- (1) That the Committee mentioned in the introduction of this report be appointed forthwith, that a report of its findings be presented to the Board of Trustees, and that a specific plan of action be presented to Oklahoma physicians as soon as possible. The plan should explain the financial condition of the Center, corrective action necessary, and what association members can do to help.
- (2) That the other activities of this committee be continued.

RESULTS OF SURVEY ON  
PRACTICE STATUS OF OU  
FEMALE MEDICAL GRADUATES

April, 1973	
Total Questionnaires Mailed	104
Total Number of Replies	68
Reply Percentage	65%
1. I am currently engaged in the practice of medicine:	
Number of Replies — 68	
Yes — 64 — 94%	
No — 4 — 6%	
2. I practice medicine:	
Number of Replies — 64	
Full time — 60 — 94%	
Part time — 4 — 6%	
3. If practice is part time, indicate approximate number of hours practice per week.	
Number of Replies — 4	
6 hours — 1	
12 to 20 Hrs. — 1	
20 hours — 1	
24 hours — 1	
4. Type of practice at present:	
Number of Replies — 63	
Private practice — 34 — 54%	
Other than private practice — 29 — 46%	
Practicing specialties — 39 — 62%	
5. Number of years you have been in practice to date:	
Number of Replies — 61	
10 years or less — 27 — 44%	
11 to 20 years — 12 — 20%	
21 to 30 years — 13 — 21%	
More than 30 years — 9 — 15%	



6. Population of area where you have practiced most of the time:

Number of Replies — 63

Under 5,000 — 5 — 8%

5,000 to 10,000 — 3 — 5%

10,000 to 50,000 — 9 — 14%

50,000 to 100,000 — 9 — 14%

Over 100,000 — 37 — 59%

7. If you do not practice at present, do you plan to return to practice in the future;

Number of Replies — 3

Yes — 1

No — 2

Full Time — 1

Part time — 0

8. Number of years since medical school graduation;

Number of Replies — 67

10 years or less — 22 — 33%

11 to 20 years — 14 — 21%

21 to 30 years — 17 — 25%

More than 30 years — 14 — 21%

9. Your present age:

Number of Replies — 67

26 to 30 — 10 — 15%

31 to 40 — 14 — 21%

41 to 50 — 20 — 30%

51 to 60 — 13 — 19%

61 and over — 10 — 15%

## TASK FORCE REPORT On the Medical Conditions

*In Oklahoma's Penal Institutions*

Prepared For

*Honorable David Hall, Governor,  
State of Oklahoma*

May 12, 1974

Donald L. Cooper, MD  
Robert M. Fogel, DO  
and  
David Bickham, Staff

## INTRODUCTION

As the state leaders address themselves to the problems of the penal system in Oklahoma, it is proper that an appraisal be made of the medical

care available to prisoners. Health care in penal institutions is a major concern throughout the United States. Recent action by State Legislatures, Federal and State Courts and by correctional organizations have helped to bring into focus the quantity and quality of health services that states are obliged to deliver, and prisoners can expect to receive.

The McAlester riot and subsequent "disorders" that followed suggested that a review of health services be initiated. Governor David Hall requested that representatives of Oklahoma Medical and Osteopathic Associations tour the state's penal facilities and provide a report on current conditions, and recommendations that could improve the medical care delivery to Oklahoma's incarcerated.

Periodically, the treatment received by prisoners emerges as one of the state's most pressing problems. A tragic incident, prisoner complaints, federal lawsuits and investigations are sufficient to arouse the public ire long enough to change prison or correction department administration but not long enough to implement long range solutions. Too often, after these brief public exposures the problem submerges and is forgotten.

Hopefully, the evaluations of this report and its recommendations will assist State leaders in developing a system for medical care that will provide necessary services to Oklahoma prisoners at reasonable costs.

Specifically, the Task Force defined its responsibilities to be:

I. Review the current medical conditions in Oklahoma's penal institutions and the adequacy of services being rendered to prisoners; and

II. Recommendations for consideration by the Administration and Board of Corrections to improve the delivery of health care services.

This report will address itself to the aforementioned topics.

Section I will attempt to compare the medical services delivered to Oklahoma prisoners with the services received by prisoners in other states or government jurisdictions. The Task Force has attempted to be realistic in its appraisal. While the recommendations of various organizations have been considered, the guidelines adopted by the Task Force are based upon requirements made by State and Federal Courts and actual medical care programs conducted in other penal institutions.

Section II is a series of recommendations which the Task Force feels will improve health care services for prisoners. The recommendations go beyond medical care services inas-



much as health is more than the absence of disease. In this context health services encompass the areas of disease prevention, mental and physical health including the maintenance, improvement and health education of prisoners.

# I. REVIEW OF THE CURRENT MEDICAL CONDITIONS IN OKLAHOMA'S PENAL INSTITUTIONS AND THE ADEQUACY OF SERVICES BEING RENDERED TO PRISONERS

## CONCLUSION

A comparison of court and legislative standards as well as recommendations of national organizations indicate that prisoners in Oklahoma have available high quality medical care, delivered by competent personnel and they receive appropriate treatment regimens for the diseases and illnesses which ordinarily occur in incarcerated populations.

While the conditions at McAlester are less than desirable for prison physicians and the sick, it is our opinion that the medical well being of the prison population is not in jeopardy.

## A. CURRENT MEDICAL SERVICES IN OKLAHOMA'S PENAL INSTITUTIONS

The Task Force visited the facilities at McAlester and Stringtown on January 2, 1974 and the facilities at Granite and Lexington on January 29, 1974.

*McAlester.* The ground floor of Cell block F has been converted into a hospital facility and while the situation is not ideal, it is adequate. Prisoners are separated and held for observation until they are discharged or referred to another facility. (University Hospital or Central State Hospital or in case of emergencies, McAlester General). On the day of our visit 41 prisoners were hospitalized. Twenty-five of these were neuro-psychiatric patients.

Sick call is held five days per week by Doctor Nilo Cater who is also the primary physician on call. Karl Sauer, MD, a McAlester physician and acting medical director sees patients one-half day each day. Daily, approximately 150 prisoners report for sick call. They are brought in small groups by a guard and are seen in a room off the rotunda near the hospital cell block. The prisoners' medical records are sent down from the administrative offices.

Drugs and rudimentary laboratory equipment are maintained in the administrative

wing of the prison. In the event tests are required that are beyond the capability of the prison laboratory facilities, the research facilities can be used. Roughly one-third of the prisoners on daily sick call are prescribed medication. It is dispensed by a cell guard according to the prescribing order.

In the event emergency treatment is necessary, the patient is taken to McAlester General. Elective procedures are sent to University Hospital or Central State. Approximately 18-24 prisoners are transported to one of these facilities monthly.

Illnesses of the prisoners are normal for a healthy, male population. There has been no problem with infectious diseases. Typical hospital admissions include, upper respiratory infection, prostate troubles, hemorrhoids, ulcers, and neuro-psychiatric problems. Jose' C. Furno, MD, a psychiatrist and member of the staff at Central State Hospital sees patients each Friday. There are approximately ten to fifteen new patients each week. In addition he sees the hospitalized N-P patients. If therapy is indicated, patients are taken to Central State and Eastern State at Vinita.

*Women's Prison.* Doctor Cater's wife attends the women's prison. There were substantial changes being made in the women's prison program at the time of our visit. Part of the inmates were being moved to Oklahoma City and the old prison facility was being phased out. Doctor (Mrs.) Cater was not interviewed, but prison officials indicated there were no significant problems in the women's program. There were 112 inmates on the date of the inspection. Medication for women inmates is transported from the men's prison as needed and dispensed the same as for men. Emergencies for women inmates are handled the same as for men.

*Stringtown.* Stringtown is the headquarters for the Plasma-phoresis program and has an excellent medical facility. Doctor Rafil Cott, a part time prison physician holds sick call four days a week while overseeing the blood plasma program. He is assisted by a prison inmate who had medical corpsman training in the Air Force. Basic first aid and non-prescription medications are kept at the facility but all complaints that require additional attention are referred to McAlester. Prescriptions are filled out of the McAlester prison and are dispensed by facility officials.

An average 25 prisoners of the 367 incarcerated at Stringtown report for sick call daily.

Elective procedures are handled the same as McAlester. Emergencies are sent to Doctor



Sauer at McAlester. Triage is handled by Stringtown administrative personnel with the help of the medical corpsman. Only 8-10 cases have required emergency treatment within the past five months.

*Honor Farm at McLeod and Vo-Tech School at Hodgins.* Medical Services rendered at these institutions are handled similar to Stringtown. There are first-aid men who have had some medical training. They are responsible for sick call and can dispense nonprescription medications. Problems are referred to Doctor Cott at Stringtown or Doctor Cater at McAlester. Prescriptions are sent from McAlester as necessary. Emergencies are sent to McAlester. Triage is done by prison officials with the help of the first-aid men. There were 127 prisoners at McLeod and approximately 375 at Hodgins.

*Lexington.* The facilities at Lexington house approximately 400 inmates. Routine medical care is provided by Mr. Tom Webb who has extensive medical training. He was a licensed psychiatrist aid in California, has had Vocational Nurse training and was a medic in the military. Mr. Webb is backed up by three physicians from Purcell (Doctors McCurdy, Long and Stover). One physician holds sick call each weekday afternoon about 5:00 p.m. Mr. Webb holds sick call each morning and discusses his findings with the physician. Approximately 75 prisoners report to sick call each day and one-half of these will be seen by the doctor.

Emergencies are taken by prison ambulance to Purcell Hospital eight miles away. The physician on call may treat or refer.

There are eight beds in the Lexington dispensary for patients under observation. Medications are kept on site and dispensed as prescribed. Drugs are purchased locally. 91 patients were on medications on the date of the visit.

There are no laboratory facilities, and a large number of workups and routine checks are sent to University Hospital, an average of 15 per week.

*Granite.* There are about 500 prisoners at the Granite Reformatory. First aid and basic medical care is rendered by Jim Davis, an inmate and certified medical technician. Billy H. Mask, DO is the prison physician and holds sick call on Monday, Tuesday and Friday. He also is the physician on call. From 12-15 prisoners report for sick call each day. Minor illnesses are treated by Davis. Doctor Mask reviews the patient records with Davis and sees approximate-

ly 10 prisoners per day. There are four other physicians in Hobart that act as consultants in Mask's absence. Emergencies are taken to Hobart, eighteen miles away, and are attended by Doctor Mask, or to Mangum. Elective procedures are referred to University Hospital and in some cases orthopedic problems are referred to an orthopedic surgeon at Altus.

There is sufficient equipment for basic laboratory tests and also an X-ray machine. Drug supplies are maintained in the administrative quarters and are dispensed by either Doctor Mask through a prison guard or by administrative officials after telephone consultation with Doctor Mask.

### SUMMARY

There is a shortage of qualified auxiliary help in each of the institutions. We think it is inadvisable for inmates to treat inmates and while there appears to be adequate supervision from physicians now, the Task Force would encourage the employment of auxiliary personnel, preferably physicians assistants or ex-medical corpsmen.

Each prisoner within a reasonable time after his incarceration should have a routine physical examination, at which time an \*immunization program should be started and a permanent medical record originated. Records should be standardized and accompany prisoners when transferred or transported, and should be maintained by non-inmates.

All laboratory, X-ray or dental equipment maintained at any of the facilities, should be inspected periodically by proper authorities or health organizations.

Referrals to University Hospital should be organized in a more efficient manner and medical reports on each prisoner should accompany the patient to and from the hospital.

*Special Note:* Currently, each institution makes its own arrangements to send patients to Oklahoma City. Guards must be provided on a 24-hour basis. At any given time there could be guards at University Hospital from several institutions. Prisoners should be segregated upon arrival and guarded by local people.

Specialty and outside consultation should be readily available to prison physicians (to some extent, this is being done now). However, some procedures are being done in Oklahoma City that could just as easily be done locally if contract arrangements could be made with local physicians and hospitals.

\*Including T.B. and HAA testing



B. STANDARDS ON HEALTH AND MEDICAL SERVICES

*National Organization Recommendations:* During the past decade or so the quality of medical care for prisoners has been the subject of considerable scrutiny. In 1955 the United Nations Congress on Prevention of Crime and Treatment adopted policies on medical services that established "Standard Minimum Rules for the Treatment of Prisoners." These guidelines, reaffirmed in 1970, have been the basis for many prison medical care programs. In summary the Rules recommend: qualified medical personnel; availability of specialized institutions or civil hospitals; dental services; special accommodations for pregnant women; and routine health care inspections.

The American Correctional Association in its Manual of Correctional Standards set forth the objectives of a health and medical services program for prisoners as one that ". . . must include the promotion of health, the prevention of disease and disability, the cure or mitigation of disease, and the rehabilitation of the patient."

Perhaps the most succinct organizational statement on the standards and goals for medical care in correctional institutions is contained in the Task Force Report of the National Advisory Commission on Criminal Justice Standards and Goals:

"Each correctional agency should take immediate steps to fulfill the right of offenders to medical care. This should include services guaranteeing physical, mental, and social well-being as well as treatment for specific diseases or infirmities. Such medical care should be comparable in quality and availability to that obtainable by the general public and should include at least the following:

1. A prompt examination by a physician upon commitment to a correctional facility.
2. Medical services performed by persons with appropriate training under the supervision of a licensed physician.
3. Emergency medical treatment on a 24-hour basis.
4. Access to an accredited hospital.

"Medical problems requiring special diagnosis services, or equipment should be met by medical furloughs or purchased services.

"A particular offender's need for medical care should be determined by a licensed physician or other appropriately trained person. Correctional personnel should not be authorized or allowed to inhibit an offender's access to medical personnel or to interfere with medical treat-

ment.  
"Complete and accurate records documenting all medical examinations, medical findings, and medical treatment should be maintained under the supervision of the physician in charge.

"The prescription, dispensing, and administration of medication should be under strict medical supervision.

"Coverage of any governmental medical or health program should include offenders to the same extent as the general public."

*State Standards.* State officials faced with increasing prison problems have identified medical services as a major concern; and a recurring complaint in prisoner actions against the state. In an effort to give direction to Correction Boards and Administrators and improve services they have promulgated formal standards and procedures. Most of these standards generally embody the same fundamentals mentioned in the national organization recommendations. California, Pennsylvania, Illinois, South Carolina and Florida are a few of the states which have established minimum levels of quality and service. States promulgating such standards vary greatly in their authority to inspect and check on compliance and even more so in their ability to insist on and order correction of deficiencies. While approximately 24 states have promulgated standards for local jails and 27 states have established inspection machinery, significant enforcement power exists in only 15 states. Thus, the mere establishment of medical or other standards is no guarantee of compliance at the state and local level although the care, detail, and professionalism invested in any given set of standards will determine its value as a guidance tool and regulatory mechanism for correctional system improvement.

*Legal Standards.* State and Federal Courts are probably most responsible for defining the level of services that states are obligated to render to the incarcerated. Since 1968 several landmark decisions concerning offender legal rights and correctional agency liabilities have added "definition" to medical health standards. *NEWMAN V. STATE OF ALABAMA* 349 F. Supp. 278 (1972)

The Plaintiff class in this civil rights suit successfully obtained federal court injunctive relief as to deficiencies in medical care throughout the Alabama penal system. The court found a neglect of basic medical needs so extreme as to be "barbarous" and "shocking to the conscience" — a standard for the granting of injunctive relief that had stymied earlier medical care litigants. The findings of fact revealed a clear



abuse of discretion by prison authorities in providing medical treatment, in the court's view. This "abuse of discretion" standard for a valid cause of action had been a difficult hurdle in prior suits. The result was the first federal court decision dealing wholly with prisoners' rights to adequate and sufficient medical care and resulting in the exercise of the equitable powers of the court to prevent further abuses.

The decree (court's order for remedial action) lists many specific areas of required improvement, such as regular physical examinations, maintenance of medical records, minimum standards for medical personnel, and keeping sufficient supplies of necessary drugs on hand. It also requires the submission of a detailed plan for a program of systemic evaluation and updating of equipment and care.

In granting the injunction the Court rules:

"... failure of board of corrections to provide sufficient facilities and staff to afford inmates basic elements of adequate medical care constituted willful and intentional violation of rights of prisoners guaranteed under Eighth and Fourteenth Amendments and intentional refusal by correctional officers to allow inmates access to medical personnel and to provide prescribed medicines and other treatment was cruel and unusual punishment in violation of the Constitution."

*SMITH V. HONGISTO*. No. C-70-1244 RHS (N.D. Cal. March 15, 1973)

In this class action plaintiffs alleged a violation of rights under the Eighth Amendment by virtue of being deprived of adequate medical care. The text of the court's decision contained the following comments regarding medical care issues.

"Minimal care, in constitutional terms requires that any inmate complaining of illness or injury be provided with reasonably prompt access to examination by a doctor of medicine, unless such medical attention has been found to be unreasonable or unnecessary by adequately trained medical or paramedical personnel, acting under precise orders and guidelines from a doctor of medicine.

"It is further essential that medical care be available at all times, either by a doctor physically present at the jail, or by one on call and available with reasonable promptness.

"It is essential, too, that there be careful compliance with the orders of doctors for medication, diet, care, hospitalization, and the re-

turn of the inmate for further treatment as ordered.

"The basic consideration is that there be a medical program so organized, staffed and administered as to assure that medical care will be available with reasonable promptness to any inmate who requires it."

*COOPINGER V. TOWNSEND*: 398 F. 2nd 392 (10th Cir.1968)

This case narrows the scope of services to which the prisoner is entitled. The prison physician refused to treat a prisoner's pre-existing medical condition in the same manner in which it was treated prior to incarceration.

The court found that the difference of opinion which existed between the lay wishes of the patient and the professional diagnosis of the doctor did not give rise to a constitutional right. "The prisoner's right is to medical care — not to the type or scope of medical care which he personally desires. A difference of opinion between a physician and a patient does not give rise to a constitutional right or sustain claim under the Civil Rights Act."

## SUMMARY

It is possible after reviewing the correctional reports mentioned, the actions of various state and court decrees that medical services to prisoners should include certain basic elements:

(1) Accessibility to reasonable medical services;

(2) The availability of proper treatment and medicines;

(3) Maintenance of treatment regimens if there is a concurrence by the prison physician;

(4) Rehabilitative treatments if substantiated by valid medical opinion;

(5) An emergency medical service plan that precludes unnecessary delay in treatment;

(6) An initial medical examination within a reasonable time after incarceration.

There are innumerable ways these elements might be organized to accomplish the Correction Department's medical service objectives. Some combinations might be more efficient than others; some organizational structures might be more formal than others; but regardless of the arrangements of the elements it is the accomplishment of the objectives that is important, and in the case of Oklahoma's incarcerated, the medical care received is of acceptable quality; is rendered within a reasonable span of time; is provided in facilities that are appropriate under existing conditions.

## II. RECOMMENDATIONS TO IMPROVE



## THE DELIVERY OF HEALTH AND MEDICAL CARE SERVICES IN OKLAHOMA'S PENAL INSTITUTIONS.

### CONCLUSION

The most important need in the Corrections Department organization is a full time, qualified medical director who has the vision and initiative to implement bold programs to improve the health environment for the total prison population throughout the State. The medical director should be selected by a Health Advisory Council named to assist the Corrections Department in this function.

*The Decision on Medical Facilities the Department Will Construct and Operate Should Be Made Soon.*

Just as there are many ways to combine the elements of good medical care to produce a quality system, such is the case with medical facilities. There have been many suggestions, most are feasible and would work, some are less expensive than others, almost all resist the construction of a general hospital behind prison walls. The Task Force feels that a qualified medical director could best make these judgments. However, in the absence of a full time Medical Director we suggest that the Administration, the Corrections Department, and legislative leaders appoint a Health Advisory Council to select the medical director and assist him in his endeavors. The Oklahoma State Medical Association may be called upon for appropriate assistance. We would suggest that the Council consist of:

- The Commissioner of Health
- The Director of Mental Health
- The Director of the Medical Research Commission
- The Director of the Department of Corrections
- The Medical Director — Department of Corrections
- The Governor
- The President Pro-Tempore of the Senate
- The Speaker of the House of Representatives
- Chairman, Board of Corrections.

Further, we recommend that a qualified health planner be employed to investigate each alternative and to present to the Council staffing requirements of each.

*An Organization Structure Should Be Designed That Places the Medical Director in Full Command of All Personnel Who Are Employed to Provide Medical or Dental Services or Supervise Programs That Directly Affect the Medical Well Being of the Prisoner.*

Either within the Department of Corrections or as an arm of some other agency a special Office of Medical Care should be established as the body having primary responsibility for the overall coordination and control of the prison health system. This is a considerable departure from existing policy but important to the overall health care program. The plasma program, medical research, the procurement of drugs or equipment and the hiring of personnel should all be the responsibility of the physician in charge. He, in turn, should report to the Chief Administrative officer of the corrections system.

*The Objectives of the Health and Medical Care Services Program Should Be Clearly Stated and Periodically Reviewed.*

Each of the penal institutions in Oklahoma's correctional system are somewhat autonomous as far as health and medical services are concerned. The director of each facility establishes his own procedures, based upon his own priorities. This is not a condemnation. In fact, some procedures employed at Granite are unique and should be used at each institution. However, there are obvious benefits to a unified system. Elective admissions to outside institutions, the coordination of medical records, combined purchasing, and the hiring of personnel are decisions that should be made in view of the overall health service program.

*A Health Care Plan With Operating Procedures Needs to Be Developed.*

There are many aspects of health care that do not directly relate to medical care but can result in good or bad medical conditions. Sanitation, diatetics, exercise, personal hygiene and mental attitude are important to the medical well being of the prisoner. The security of knowing that someone is at least interested in the environment to which the prisoner is confined is therapeutic in itself. Periodic inspections by officials of the Mental and Public Health Department; a review of menus by a qualified dietitian; a review of work programs and prison facilities may not require substantive changes, but would lead to public confidence in the corrections program.

*The Expenditures for Medical Services Should Be Clearly Delineated in The Corrections Department Budget.*

We are of the opinion that a top-notch medical administrator will want to know how much money he has to work with. All funds accruing to the Department as a result of research programs, the plasma program or grants from drug manufacturers should be included in the medical budget and not considered recurring funds.



May 12, 1974

(APPROVED AS AMENDED)

*Council Members*

The interest of the before mentioned parties wax and wane and reliance on continued support may be unwise. The system may be expending necessary funds but the medical budget is not identifiable.

*There Should Be Considerable Exploration of the Use of Allied Health Personnel.*

Oklahoma has a model Physicians' Assistant law and training program. There are currently experimental programs being conducted in the state utilizing this new medical resource and apparently citizens are accepting his services with confidence.

It is entirely possible that properly established training could be initiated that would expose the PA to prison medicine. The competency of the graduates would not compromise the quality of care and would offer a new reservoir of talent from which to obtain additional medical help.

It has been suggested that preceptorship arrangements for medical students could be extended to the McAlester facility. While this may be possible, it is important to remember that a preceptee is a *student* and must be involved in training programs with proper instruction and supervision.

*An Opinion Needs to be Requested of the Attorney General About the Individual Liability of Medical Personnel and Medical Facilities When Treating Prisoners.*

In order for the prison medical care system to have available the diversity of medical services necessary, it is important that the liability of physicians and medical facilities be clearly established. If there is a method of granting immunity then it should be pursued. During interviews with several physicians who render care to prisoners, this subject was discussed. There is obvious concern about lawsuits as a result of care to prisoners.

*SUMMARY*

There are other worthwhile suggestions that should be considered — a centralized induction center for initial screening, a maximum security wing at the new McAlester hospital, contracts with individual physicians and facilities, but all lead to the same conclusion. The Health Care Program of the Oklahoma Corrections Department needs direction. Thus, it is imperative that a full time, qualified medical-administrator be employed as soon as possible.

Report of the  
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## **SECTION I THE COUNCIL**

It is axiomatic that almost every aspect of the practice of modern medicine deals directly with public health. Your association's Council on Public Health has the primary function of coordinating the OSMA's activities in this area.

The majority of the council functions are carried out through specialized committees. During the past year these committees have worked on a number of important programs that directly affect the public health.

In addition to specific projects, your council must constantly monitor a number of different activities going on around the state. As an example, a venereal disease education project is now being conducted by the Oklahoma Department of Public Health. While this is not an OSMA program, it is endorsed by the association and the association's staff has assisted in the publication and promotion of this activity.

One result of the venereal disease program may be seen in the half-day venereal disease seminar being offered during Oklahoma Medical Summit.

Your association, via this council, has been concerned for several years over the medical situation in the state penitentiary. In 1969 the association appointed a special committee to study the medical care being rendered at the state's penal institutions.

Your association is again working closely with the administration and prison officials to help them solve their medical service difficulties. A special report to the Governor is attached to and made a part of this report of the Council on Public Health.

In its report to the House of Delegates last year, your council made mention of the lack of quality health curriculum in Oklahoma's pub-

lic school systems. One of the recommendations adopted by the House was that the OSMA continue to encourage the State Board of Education and State Superintendent of Public Instruction to develop a quality health education curriculum for the public schools for grades 1 through 12.

The culmination of this recommendation was the introduction and passage of Senate Concurrent Resolution No. 98. The resolution begins by recognizing that Oklahoma public school children possess "less knowledge of good health practices than do their counterparts in other states." It ends with three recommendations: ". . . that the State Department of Education upgrade and improve the health education programs in the public schools of the state of Oklahoma" . . . "that the State Department of Education, with the approval of the State Board of Education, establish a definite time allocation for the teaching of health education in the Oklahoma Public Schools, (kindergarten) through 12." . . . and, "that the Oklahoma Legislature recognize the need for appropriate funding of these health programs and the need for employing qualified teachers to conduct health education programs, and urge a line item appropriation necessary for implementation of this program."

This resolution was adopted by the Oklahoma Senate on January the 16th and was concurred in by the House of Representatives on January 21st.

As of May 1st, (the time of the writing of this report), a \$78,000 line item appropriation was pending before the Oklahoma Legislature. If the appropriation is passed into law, its purpose will be to implement the recommendations found in this resolution.

For the past three years one of the activities constantly monitored by your council has been the National Health Service Corps. This was the program that sent volunteer doctors to medically needy communities to practice medicine for one or two years.

The basis of the Corps popularity was that it could, in some instances, replace service in the United States Military Medical Corps.

The end of a doctor draft, and the end of a threat of not being allowed to practice "civilian type" medicine also brought an end to the volunteers for the National Health Service Corps. There will be a few physicians who will volunteer for the program and subsequently your council will continue to monitor its activities in the state of Oklahoma.

Last August your association became involved in the aerosol spray controversy. A



physician at the Children's Memorial Hospital in Oklahoma City reported to the Consumer Products Safety Commission his fear that certain types of aerosol spray adhesives were resulting in chromosomal breaks that could lead to deformed infants.

CPSC investigators came to Oklahoma and met with the physician, reviewed his research, and concluded that his findings strongly suggested a causal relationship between exposure to these spray adhesives . . . which were used in a very popular home hobby at the time . . . and findings of chromosome damage in birth defects in a group of subjects he had studied. The removal of the sprays from the market led to an overwhelming public interest in the subject. Inquiries were received from throughout the United States about what could or should be done by young women of child bearing age who had been involved in the home art craft hobby known as "foiling" or "foil art."

After extensive interviews with the doctor, the OSMA issued to all of its members a four-page "Medical Information Re: Aerosol Spray Adhesives." This was also circulated, to a limited extent, nationally.

Although this particular controversy has now died down, at the time it originally arose it required several days of intensive work by your association's officers and staff to formulate and execute a plan designed to dispatch the maximum amount of information available to all physicians in the state. This is just one example of your association's activities in regard to "the public health."

## SECTION II COMMITTEE ON ALCOHOLISM AND DRUG ABUSE

Following the recommendation made last year, immediately after the House of Delegates met, your committee set about to update and republish its "Drug Abuse Treatment Manual."

The republished manual contained new information on the diagnosis and treatment of certain drug overdose situations. In addition, it contained a directory of the drug treatment and counseling agencies available throughout the state.

Notice that the updated manual was available, was given to all members of the association through the OSMA Comment and OSMA Journal. Well over 300 copies were distributed to individuals, and all of the drug abuse counseling and treatment agencies received several copies each for their libraries.

Also following a recommendation from the

last House of Delegates, your committee has constantly promoted the use of the 30 minute film entitled "What Did You Take?". This film was prepared in cooperation with the New York Medical Society and is designed to instruct physicians and other emergency care personnel in the emergency treatment of overdoses of heroin, barbiturates, amphetamines and LSD.

During the past year the film has been used an average of four to six times each month. Primarily it is being shown to hospital staff meetings. However, on a few occasions it has been shown to general lay audiences. While the film is not really suitable for showing to the general public, in each instance the decision to show it to a lay audience has been made by a physician.

One of the first actions of your committee during the past year was to set up a meeting of all organizations interested in drug abuse education. The purpose of the meeting was simply to allow the organizations to exchange ideas and information on their various programs for the benefit of all.

Public education on the subject of drug abuse has not been a prime activity of your committee for the last several years. The committee has felt that it could best spend its time educating association members about this perplexing problem. However, members of the committee and the association staff have made well over 50 drug abuse presentations to civic groups, church groups, schools, etc., during the past year.

Although the name of the committee is the "Alcoholism and Drug Abuse Committee," during the past few years almost all of its emphasis has been on drug abuse. A renewed interest in alcoholism and the problems it creates for industry and the various professions, including the medical profession, is beginning to be seen.

## RECOMMENDATIONS:

1. It is recommended that the committee on Alcoholism and Drug Abuse be instructed to establish a public information program on Alcoholism and Drug Abuse. A speaker's bureau on these two subjects should be considered, possibly combined with a speaker's bureau for the entire association.

2. It is recommended that the Committee on Alcoholism and Drug Abuse be instructed by the House of Delegates to continue its work with other interested organizations in an attempt to coordinate drug abuse and alcoholism information programs throughout the state.

3. It is recommended that all county medical societies and all hospital staffs in Oklahoma,



that have not already done so, be urged to request and use the film "What Did You Take?" as a program sometime during the upcoming year.

*SECTION III*  
*COMMITTEE ON IMMUNIZATION*

During the past year your Immunization Committee has not functioned. No immunization problems nor projects were directed to it either from within the OSMA or by the Oklahoma Department of Public Health.

The primary purpose of the committee is to advise the Department of Public Health on questions of immunization and to assist them in publicizing immunization campaigns.

One comment does need to be made, however. The state law requiring basic immunizations prior to entry into the Oklahoma School System for the first time has, to a degree, contributed to a lack of immunization earlier in the child's life. This lack of immunization led to last year's polio immunization campaign. Many parents simply found it more convenient to wait until the child was beginning school before starting an immunization program.

All OSMA members should encourage the parents of their small patients to begin immunization schedules as soon as possible.

*SECTION IV*  
*COMMITTEE ON EMERGENCY*  
*MEDICAL SERVICES*

A developing interest in the rapid and safe transportation of the sick and injured to definitive medical care precipitated the creation of this committee on Emergency Medical Services for the OSMA. Activities to improve communications between emergency personnel and medical facilities, training programs for emergency medical technicians, increased first aid requirements for ambulance personnel, helicopter evacuation of the sick and injured, . . . all are ongoing programs in the area of emergency medical services.

The MAST Program, Military Assistance to Safety and Traffic, is now operational in the state of Oklahoma. MAST allows US Army helicopters to transport the sick and injured. It is the result of an inter-agency agreement between the Departments of Defense, Transportation and Health, Education and Welfare.

The MAST operational area in Oklahoma and Texas is a 100 mile radius circle around Fort Sill, where helicopters to be employed are permanently based. A "MAST Mission Handbook" has been issued to all hospitals in the 32 Oklahoma and 16 Texas Counties inside the

circle. The handbook sets out the procedures necessary to call a MAST Mission.

Helicopter transportation via MAST can be called on 24 hours a day, seven days a week. However, the program is not to be used for routine transfers or in cases where transportation could be accomplished as quickly by ground ambulance.

A serious medical emergency is defined as, ". . . a situation in which an individual's perceived condition requires air transportation to a medical center (or air transportation of medical material or personnel) as quickly as possible in order to prevent his death or the aggravation of his illness or injury, and in which the use of alternative means of transportation will not accomplish that result."

If the MAST Program is utilized, once the patient is in the air, the aircraft commander is in charge of all persons on board. One family member may accompany patients, but they are responsible for arranging for their own return transportation.

*SECTION V*  
*MATERNAL MORTALITY COMMITTEE*

This committee, although a function of your state medical association, has authority in the statutes of Oklahoma for its operation. Its purpose is to review the medical evidence connected with maternal death in Oklahoma for the purpose of verifying the cause of death, deciding if a death was preventable and determining whose responsibility the death was.

The statutes provide that studies for the purpose of reducing morbidity or mortality may be conducted and that confidential information may be provided to the State Board of Health; . . . "The Oklahoma State Medical Association, or any committee or allied society thereof; the American Medical Association, or other national organization approved by the State Board of Health, or any committee or allied medical society thereof; . . .", to that end.

The statute goes on to provide that no liability for damages may be enforced against any authorized person or institution who has provided information or material to such a committee. All information is to remain confidential, although the committee is given the authority to publish summaries of its studies. "In all events," the statute states, "the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances. Any information furnished shall not contain the name of the person upon whom information is furnished and shall not violate the confidential relationship of patient and doctor." The statute



then goes on to declare all such information to be privileged communications that may not be offered or received in evidence in any legal proceeding.

Cases to be reviewed are discovered by the State Health Department through a screening mechanism. All death certificates of women of child bearing age are carefully reviewed to determine whether or not the death might be classified as a maternal mortality. The attending physician is asked to fill out a questionnaire regarding the case. Information is also sought from additional physicians that were known to have been involved in the case. The reports are reviewed by a member of the maternal mortality committee and a commentary is prepared and presented to the committee as a whole. Each case is discussed in detail and a written report is forwarded to the physicians involved.

For some years there has been a fear that the anonymity of the patient and physician involved might be violated if a specific case report was published in the *OSMA Medical Journal*. Your committee is attempting to work out an exchange program with committees in other states so that representative cases can be printed in Oklahoma, and vice versa. By not revealing the state of origin of the case, and requiring that the other states do the same, the anonymity of all persons involved will be protected. At the same time, Oklahoma physicians will gain the benefit of knowing what has happened in maternal mortality situations.

Concern that the screening mechanism being used might miss a case has led the committee to seek some additional method for determining whether or not any given death might have involved a maternal mortality. One suggestion has been made that a statement be placed on the death certificate inquiring as to whether or not the deceased had been pregnant during any part of the last 90 days of life.

Another possibility that might result in an in-depth investigation would be to declare a maternal mortality to be a medical examiner case.

New ways to determine whether or not a maternal mortality has occurred might be unnecessary if physicians could be encouraged to work with the committee whenever they receive a maternal mortality questionnaire. The functions of the committee are not punitive, they are educational. Its purpose is to ferret out and eliminate, if possible, the causes of preventable maternal mortalities.

At the present time the committee relies almost entirely upon the questionnaire that is

received from the attending physician at the time of death for its information. It has been proposed that the committee consider sending one of its members, or one of the "older and more revered" members of the profession, to personally investigate the death. This could be done by reviewing the hospital and physician's records and through personal contact with the physician involved. The committee will continue to seek a better method of evaluating maternal mortalities.

The statutes indicate that the purpose of the committee is really educational in nature. Because of past reluctance to publish cases, your committee has really defaulted its responsibilities in this area. However, we have contacted the program chairman for the 1975 Annual Meeting of the Oklahoma State Medical Association and requested time and space to present a half-day seminar on the subject of the prevention of maternal mortality.

The chairman of your committee recently presented a paper on the workings of maternal mortality committees throughout the south, and specifically in Oklahoma, to the OB-GYN Section of the Southern Medical Association meeting.

A possible educational function of the committee is based on an idea that comes from Mississippi. The maternal mortality committee in that state published a set of "Maternal Health Desk Cards." These cards, actually a book in nature, outline procedures to be followed whenever a physician is faced with an obstetrical emergency. Your committee currently has the cards under study and would like to see them published for Oklahoma and distributed to all hospital delivery rooms.

A technical problem was called to your committee's attention during the last year. The statute in Oklahoma, as set out at the first of this report, specifies that members of the state medical association may participate in maternal mortality committees. Provision is not specifically made for osteopathic physicians to participate in the committee functions. The committee is frequently called upon to review a maternal death involving an osteopathic physician. Legal counsel has been asked to determine whether or not an osteopathic physician could be assigned by the State Health Department to assist the committee in its deliberations. It may be necessary to seek a legislative change in the statute to correct this oversight.

The committee also considered the possibility of involving itself in studies involving neo-natal mortality. After some deliberation, however, the committee determined that under its present structure and staffing situations, this added responsibility would entail too much work.



The report made to the Southern Medical Association, cited above, was based on a very extensive survey conducted by the committee during the past year. Every state was asked for a copy of their maternal mortality operational procedures. Almost all of them responded. This information is being studied to determine if other states are following procedures that could be used in Oklahoma.

#### **RECOMMENDATIONS:**

1. It is recommended that the House of Delegates authorize the Maternal Mortality Committee to publish a "Maternal Health Desk Book" to be distributed to all hospital delivery rooms and to all members of the association.

2. It is recommended that the House of Delegates authorize the Maternal Mortality Committee to continue its efforts to disseminate maternal mortality information to all physicians that deliver babies.

### **SECTION VI**

#### **COMMITTEE ON LABORATORY QUALITY**

For six years Oklahoma physicians have participated in office laboratory evaluation programs. Oklahoma was one of the first states in the nation to successfully promote proficiency testing among its members and has led the nation in the percentage of physicians participating each year.

The committee approved the College of American Pathologists Proficiency Evaluation Program for the 1974 laboratory testing program. PEP is designed for the physician's office. Specimens are sent eight times a year to each participating laboratory, and provide the opportunity for 108 evaluations. This is an improvement over previous years when constituents were mailed each quarter. Results are tabulated by a centralized computer service and compared with other participating laboratories in the United States. The reports prepared for members compare results with a standard mean and make a statistical evaluation of the acceptability of the results. This committee periodically reviews laboratory results and establishes medical acceptability.

Participating Oklahoma physicians have improved the quality of their laboratory practice as a result of this program. New testing methods have been implemented by some laboratories, shortcomings of personnel have been identified and some testing has been discontinued because of their technical complications. Hopefully, our committee can, in the

foreseeable future, produce for Oklahoma physicians a standard guide for operating a physician's office laboratory.

When the program was initiated in 1968-69, we had twenty-five physician's office laboratories enrolled. This year there are fifty-five, a small decrease from a high of about 70 two years ago. However, some physicians are enrolled in the more comprehensive Basic Survey Program, a report not available at the writing of this report.

As government involvement in medicine increases it is apparent that there will be more requirements to demonstrate medical competence in every area. Some states have enacted legislation requiring physicians that have office laboratories to participate in testing programs. It is the opinion of the committee that voluntary participation is far more acceptable than compulsory participation and we would encourage every physician that conducts laboratory tests in his office to enroll in a quality control program.

The committee will attempt to identify the physician office laboratories in Oklahoma in order to promote PEP. Too, we feel one of our most important roles is continuing education of physicians and their laboratory personnel. There are many educational opportunities available to "techs" and this will be disseminated. Our primary objective will be to improve the quality of laboratory results, by working with the physician-director and his laboratory personnel.

#### **RECOMMENDATIONS:**

It is recommended that the activities of the committee be continued.

Report of the  
COUNCIL ON SOCIO-ECONOMIC  
ACTIVITIES  
May 12, 1974  
(APPROVED)

#### *Council Members*

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Thurman Shuller, MD, McAlester  
Walter E. Brown, MD, Tulsa  
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Howard B. Keith, MD, Shattuck  
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Robert R. Dugan, MD, Oklahoma City  
Robert Sukman, MD, Oklahoma City  
Harold Stout, MD, Waurika  
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### PEER REVIEW COMMITTEE

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Chairman

G. Rainey Williams, MD, Oklahoma City,  
Chairman

Leonard H. Brown, MD, Tulsa

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Frank L. Adelman, MD, Enid

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W. R. Smith, MD, Enid

Samuel A. Wheeler, MD, Oklahoma City

Tony Puckett, MD, Oklahoma City

Jack L. Richardson, MD, Tulsa

Charles R. Gibson, MD, Chickasha

Roger Haglund, MD, Tulsa

Fred Switzer, MD, McAlester

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Robert M. Shepard, Jr., MD, Tulsa

### PEER REVIEW COMMITTEE

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Alfred H. Bungardt, MD, Tulsa

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### SECTION I

#### PEER REVIEW COMMITTEE

Peer Review has been a function of your association for many years. With the enactment of Medicare in 1966, the association established a Peer Review or Insurance Review Committee.

The purpose of the committee throughout the years has been to adjudicate claims involving health care programs which reimburse physicians according to "usual, customary and reasonable" fees.

Since 1966 the structure and organization of the committee has changed. As the number of cases began to increase, it was necessary to split the committee into two subcommittees, each with its own chairman, to meet on alternate months. Two years ago the House of Delegates authorized the committee to change its name from "Medical Insurance Review" to "Peer Review."

The primary purpose of the committee over the years has been fee adjudication. Even if a Professional Standards Review Organization is created in Oklahoma, it is prohibited by law from involving itself in fee disputes.

Whether the OSMA chooses to become a PSRO sponsoring organization, or it is sponsored by some outside organization, it will still be necessary for your association to maintain a fee review mechanism to adjudicate claims. The current mechanism assures our members that they will receive a fair hearing on their fees by persons who are familiar with the problems of private practice.

During the past 12 months, beginning with the committee's meeting in April of 1973, the 20 members of the two peer review sub-committees have reviewed 168 cases, some involving multiple charges and/or multiple patients.

It should be understood that the term "cases" as used in this report does not necessarily mean that the committee considered only a single claim. In many cases numerous claims were involved. Although the total amount of money in controversy in any one case might not be much, the case could establish precedent for the carrier to follow in the future. As an example, if the committee recommends that the carrier recognize a higher fee for a given procedure, the recommendation will affect not only the outcome of the case in question, but all other charges received for the same procedure by the carrier.

Of the 168 cases considered in the past 12 months, 107 involved Oklahoma Blue Shield. Medicare accounted for 24 cases, the Department of Institutions, Social and Rehabilitative Services was involved in 10, and private insurance companies accounted for 27.

The Peer Review Committee has now operated for three years under the subcommittee system. During that time, even with intercommunications, the decisions of the two commit-



tees have tended to differ. The incoming OSMA President, Jack L. Richardson, MD, (a long time member of the committee) has recommended that the two committees meet jointly on occasion to resolve their philosophical and organizational differences. The first such meeting will be held early this summer.

## PROPOSED AMENDMENTS TO THE BY-LAWS OKLAHOMA STATE MEDICAL ASSOCIATION

### *Resolution No. 1* (DISAPPROVED)

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: Deletion of Requirement for Mandatory Membership in American Medical Association from the By-Laws of the Oklahoma State Medical Association.

REFERRED TO: Reference Committee No. I

It is proposed that Chapter I, Section 1.00 of the By-Laws be amended as follows:

The last sentence in the paragraph, which now reads "All members of component societies and of this association are required to belong to the American Medical Association," shall be amended to read as follows:

"Members of this association are not required to belong to American Medical Association, but each member at his option may elect to assume membership in American Medical Association."

It is further proposed that Chapter II, Section 2.00 shall be amended to read as follows:

"Section 2.00. AMERICAN MEDICAL ASSOCIATION DUES. Members of this association are not required to belong to American Medical Association. For those members who voluntarily elect to assume membership in American Medical Association, AMA dues and assessments shall be collected and remitted in the manner provided by the By-Laws of the American Medical Association."

It is further proposed that Chapter V, Section 7.036 of the By-Laws be amended to read as follows:

"7.036. APPEALS TO THE AMERICAN MEDICAL ASSOCIATION. Judicial decisions of the Board of Trustees which affect members of the American Medical Association may be appealed to the Judicial Council of the American Medical Association in accordance with that organization's Constitution & By-Laws. In such event the decision of the Board of Trustees shall not be suspended pending the appeal to

the AMA Judicial Council. Members of the Oklahoma State Medical Association who elect not to become members of the American Medical Association, may not appeal adverse judicial decisions to the American Medical Association."

### *Resolution No. 2* (APPROVED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Standardized College Physical Examinations

REFERRED TO: Reference Committee No. III

Whereas, Every university and college student health unit has designed their own unique criteria for acceptable entrance examinations; and

Whereas, Since college students' transfer between institutions is thereby made more costly and laborious without any corresponding health benefit; and

Whereas, Physician services are needlessly expended in processing these transfers; therefore be it

*Resolved*, That the OSMA develop a standard college entrance physical form and promote its adoption for Oklahoma colleges and universities for both entering and transferring students.

### *Resolution No. 3* (APPROVED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Pre-Existing Illness In Medical Health Insurance

REFERRED TO: Reference Committee No. I

Whereas, It frequently occurs that insurance providers refuse to pay for medical services rendered to policyholders; and

Whereas, It frequently occurs that policyholders have in good faith maintained payments and continued health insurance in force only to find after the fact that certain illnesses are not covered; and

Whereas, Most policies are sold with the medical exclusions listed under the all encompassing "pre-existing" illnesses; and

Whereas, Most companies investigate the medical background of their policyholders and know the type and, in fact, specific illnesses for which it will not pay; and

Whereas, Most policyholders are not notified of specific illnesses and situations not covered; therefore be it



*Resolved*, That the Oklahoma State Medical Association supports legislation and/or regulations requiring medical policyholders to be notified in writing of specific illnesses and situations which will not be covered before premiums are collected or the policy goes into force. The statement "pre-existing illnesses" will not suffice — the specific illness must be spelled out.

*Resolution No. 4*

(APPROVED AS AMENDED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Development of Family Medicine

REFERRED TO: Reference Committee No. III

Whereas, the state of Oklahoma has a widespread and urgent need for more physicians in the primary care specialties, and particularly in family practice; and

Whereas, since the academic progress of the family practice program at the medical school could be expedited in many ways; therefore be it

*Resolved*, That the Oklahoma State Medical Association commend the University of Oklahoma School of Medicine for its support of the Family Medical Program and, further, recommends continued improvement in both the financial support and the availability of in-patient care space for this valuable program.

*Resolution No. 5*

(APPROVED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: PSRO Repeal

REFERRED TO: Reference Committee No. II

Whereas, The malignant effects of PL 92-603 on the delivery of medical care and quality of medical services is readily apparent to most physicians; therefore be it

*Resolved*, That the OSMA undertake an active program to inform the populace of Oklahoma of these ill effects, and to ask the Oklahoma Congressional delegation to effect repeal of this bad law.

*Resolution No. 6*

(APPROVED)

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: PSRO

REFERRED TO: Reference Committee No. II

Whereas, The Board of Directors of Tulsa County Medical Society has passed a resolution on October 31, 1973, "favoring the repeal of PSRO provisions of Public Law 92-603"; and

Whereas, The Oklahoma State Medical Association passed a resolution in April, 1973, favoring opposition to the PSRO provisions of Public Law 92-603; and

Whereas, The House of Delegates of the American Medical Association passed a resolution at Anaheim, California, November, 1973, stating, "The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation"; and

Whereas, Thirty-four members of Congress wrote an open letter to the House of Delegates of the American Medical Association urging them to "pass a resolution specifically calling for the repeal of PSRO and committing the all-out efforts of the American Medical Association to that end"; and

Whereas, The American Medical Association Board of Trustees has taken the position that the action of the House of Delegates in Anaheim was "an opinion, not a call for direct and immediate action to repeal this section of Public Law 92-603 that creates PSRO"; therefore be it

*Resolved*, That the Oklahoma State Medical Association by action of its House of Delegates calls for immediate and direct action by the American Medical Association in an all-out effort to work for the repeal of that section of Public Law 92-603 that creates Professional Standards Review Organization.

*Resolution No. 7*

(DISAPPROVED FOR SUBSTITUTE RESOLUTION)

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: PSRO

REFERRED TO: Reference Committee No. II

Whereas, The Board of Trustees of the American Medical Association has seen fit to take legal action, if necessary, to block pre-certification and Phase IV regulations; and

Whereas, Pre-Certification is a part of the PSRO Law "Sec. 1155.(a) (2) (A) (3)", Page 105, Public Law 92-603; and

Whereas, The Association of American Physicians and Surgeons, Inc., 2111 Enco Drive, Oak Brook, Illinois, and Roy Grenker,



Sr., MD; George E. Shambrough, Jr., MD; and Edward A. Walpert, MD have filed suit in the United States District Court of Illinois Eastern Division on June 26, 1973, against Casper W. Weinberger, Secretary of Health, Education, and Welfare in order to have the PSRO law declared unconstitutional; and

Whereas, This course of action is in the best interest of the American people, our patients; and

Whereas, This course of action would be strengthened by amicus curiae action; therefore be it

*Resolved*, That the Oklahoma State Medical Association will enter here-to-fore mentioned lawsuit as amicus curiae and will urge the other 49 State Medical Associations and the American Medical Association to do likewise.

#### *Substitute Resolution 7*

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: PSRO

REFERRED TO: Reference Committee No. II

Whereas, the Board of Trustees of the American Medical Association has seen fit to take legal action, if necessary to block pre-certification and Phase IV regulations; and

Whereas, Pre-certification is a part of the PSRO Law "Sec. 1155. (a) (2) (A) (3)", Page 105, Public Law 92-603; and

Whereas, the Association of American Physicians and Surgeons, Inc., 2111 Enco Drive, Oak Brook, Illinois, and Roy Grenker, Sr., MD; George E. Shambrough, Jr., MD; and Edward A. Walpert, MD have filed suit in the United States District Court of Illinois Eastern Division on June 26, 1973, against Casper W. Weinberger, Secretary of Health, Education, and Welfare in order to have the PSRO law declared unconstitutional; and

Whereas, this course of action is in the best interest of the American people, our patients; and

Whereas, This course of action would be strengthened by amicus curiae action; therefore be it

*Resolved*, That the OSMA Board of Trustees consider carefully the action of AMA at its upcoming meeting in June in regard to legal action to declare the PSRO law unconstitutional. In the event that AMA does not take legal action to declare said law unconstitutional, then OSMA will enter into negotiations with other state medical societies and, if a substantial number concur and agree, then OSMA will join

others in legal action seeking declaration that the PSRO law is unconstitutional.

#### *Resolution No. 8*

#### *(DISAPPROVED FOR SUBSTITUTE RESOLUTION)*

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: PSRO

REFERRED TO: Reference Committee No. II

Whereas, The federal government, in its penchant for experimental programs, as evidenced by testing the efficacy of Health Maintenance Organizations prior to nationwide implementation, has not attempted to establish a meaningful experimental program to evaluate the cost and quality effectiveness of Professional Standards Review Organizations; and

Whereas, Public Law 92-603 imposes PSRO on all non-federal hospitals of the United States certain untried regulations and controls which will revolutionize the health care delivery system and affect the benefits available through the Medicare and Medicaid programs; and

Whereas, The economic savings and quality elevation benefits to be anticipated from PSRO are in speculative balance as compared to unknown costs of administration, potentially disastrous effects on hospital solvency, and possible counter-productivity in the quality of health care and medical progress; and

Whereas, A network of federal hospitals, the United States Veterans Administration hospitals, provides an excellent opportunity to evaluate the PSRO program in advance of a nationwide review of the performance standards of private doctors and hospitals; therefore be it

*Resolved*, That the Oklahoma State Medical Association seek a moratorium on the implementation of Section 249F of Public Law 92-603 until such time as the provisions of this law have been tested for two years through experimentation in US Veterans Administration Hospitals in Oklahoma and elsewhere, which are more clearly a responsibility of the US Congress; That the results of this study be published and publicly disclosed.

#### *Resolution No. 8*

#### *(APPROVED AS AMENDED AS SUBSTITUTE RESOLUTION)*

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: PSRO

REFERRED TO: Reference Committee No. II

Whereas, the federal government, in its penchant for experimental programs, as evidenced



by testing the efficacy of Health Maintenance Organizations prior to nationwide implementation, has not attempted to establish a meaningful experimental program to evaluate the cost and quality effectiveness of Professional Standards Review Organizations; and

Whereas, Public Law 92-603 imposes PSRO on all non-federal hospitals of the United States certain untried regulations and controls which will revolutionize the health care delivery system and affect the benefits available through the Medicare and Medicaid programs; and

Whereas, the economic savings and quality elevation benefits to be anticipated from PSRO are in speculative balance as compared to unknown costs of administration, potentially disastrous effects on hospital solvency, and possible counter-productivity in the quality of health care and medical progress; and

Whereas, a network of federal hospitals, the United States Veterans Administration hospitals, provides an excellent opportunity to evaluate the PSRO program in advance of a nationwide review of the performance standards of private doctors and hospitals; therefore be it

*Resolved*, that PSRO standards be applied to all federal institutions receiving tax funds and caring for patients receiving government medical benefits including VA hospitals, Public Health Service hospitals, Indian Health Service hospitals and military hospitals.

*Resolved*, That the legislative department of the American Medical Association be requested to draft legislation accomplishing this result; and

*Resolved*, That the leadership of the Oklahoma State Medical Association present this proposed legislation to Oklahoma's Congressional Delegation for introduction in the 93rd Congress.

*Resolution No. 9*

(WITHDRAWN)

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: Disposition of AMA Dues Incentive Income.

REFERRED TO: Reference Committee No. I

Whereas, The American Medical Association has instituted an incentive program for early payment of membership dues, whereby it pays one-half of one per cent above the prime rate for all AMA dues collected and received in the Chicago headquarters from January 1 to April 1,

with interest paid through April 30 of each year; and

Whereas, The American Medical Association also pays to constituent state medical associations the sum of one per cent of AMA dues collected; and

Whereas, The actual collection of Oklahoma State Medical Association and American Medical Association dues is customarily done by county medical societies through their own expense and effort; and

Whereas, The effectiveness of the AMA dues payment incentive program depends upon the early collection and remission of OSMA and AMA dues; and

Whereas, In the absence of an incentive to county medical societies for early collection and remission of AMA and OSMA dues, the policy of retaining such funds in Certificates of Deposit at the local level may be justifiably expected to continue; and

Whereas, The withholding of AMA and OSMA dues until the due date of March 31 deprives Oklahoma State Medical Association of the use of such funds for both operational and investment purposes; therefore be it

*Resolved*, That the Oklahoma State Medical Association follow the leadership of other state medical associations over the nation by passing on to its component county medical societies all income received from (1) the dues payment incentive program of American Medical Association, and (2) the one per cent collection rebate of American Medical Association, such action to be taken in acknowledgment of the function of the county medical societies in collecting such funds; and be it further

*Resolved*, That the participation be limited to those county medical societies which actually collect and remit OSMA and AMA dues to Oklahoma State Medical Association; and be it further

*Resolved*, That the Executive Committee be empowered to adopt such rules for operation of this program as shall be fair and shall assure prompt payment to the participating county medical societies.

*Resolution No. 10*

(DISAPPROVED FOR SUBSTITUTE  
RESOLUTION)

INTRODUCED BY: Comanche-Cotton-Tillman County Medical Society

SUBJECT: PSRO Repeal

REFERRED TO: Reference Committee No. II  
Whereas, The PSRO (Professional Standards



Review Organization) standards of medical care are being applied to all Medicare and Medicaid patients at this time, or soon will be, and since the United States Congress considers this to be important in controlling the quality and cost of medical care; therefore be it

*Resolved*, That this medical society sees this law as the creating of another bureaucracy which will accomplish neither the improvement of care nor the reduction of costs and recommends the repeal of the law; and be it further

*Resolved*, That if repeal cannot be accomplished, these same PSRO standards be applied to the care of all patients for which the federal government is providing, and that the PSRO law be amended to provide the same standards of excellence in the care of patients in all federal institutions including VA hospitals, Public Health Service Hospitals and Military Hospitals.

*Resolution No. 11*

*(APPROVED AS AMENDED)*

INTRODUCED BY: Comanche-Cotton-Tillman County Medical Society

SUBJECT: Ad Hoc Committee on Fees

REFERRED TO: Reference Committee No. III

Whereas, there is currently a practice referred to as establishing a "fee profile" for each physician caring for certain patients whose medical care is provided for by a third party which allows for a sometimes marked discrepancy in fees for identical services; therefore be it

*Resolved*, That an ad hoc committee be appointed by the President of the Oklahoma State Medical Association with instructions to explore every possible legal method to change this practice and obtain equity in the reimbursement to physicians.

*Resolution No. 12*

*(DISAPPROVED)*

INTRODUCED BY: Comanche-Cotton-Tillman County Medical Society

SUBJECT: Voluntary AMA Dues

REFERRED TO: Reference Committee No. I

Whereas, The Trustees of the American Medical Association have not carried out the desire of the majority of its members in seeking repeal of PSRO but instead have informed the Secretary of Health, Education and Welfare that they would help implement PSRO; therefore be it

*Resolved*, That the Oklahoma State Medical Association allow licensed physicians living and practicing in Oklahoma the option of be-

longing to their county society and the state association without paying dues to the American Medical Association.

*Resolution No. 13*

*(APPROVED AS AMENDED)*

INTRODUCED BY: Carter-Love-Marshall Counties Medical Society

SUBJECT: Continuing Medical Education (CME)

REFERRED TO: Reference Committee No. III

Whereas, the greatest need for CME exists at community hospital levels; and

Whereas, having CME in community hospitals will cause the least disruption of professional activities and cost the least; and

Whereas, co-sponsorship by the Oklahoma State Medical Association at local levels ensures a better chance of CME success; and

Whereas, the American Medical Association endorses co-sponsorship; therefore be it

*Resolved*, That the Council on Professional Education of the Oklahoma State Medical Association, in conjunction with the University of Oklahoma Health Sciences Center, the medical school, specialty medical societies, hospitals, and volunteer health organizations, should develop plans to provide at local levels, courses approved as meeting the standards and requirements of the AMA Physician's Award of Merit, AAFP, ACP, etc., postgraduate CME;

*Resolved*, that the OSMA should enter into a contract with the University of Oklahoma Medical School Office of Continuing Education to formulate a plan to carry out the interest of this resolution. Such contract should be for an amount of \$1,000.

*Resolution No. 14*

*(APPROVED)*

INTRODUCED BY: Garfield County Medical Society

SUBJECT: American Medical Association Membership

REFERRED TO: Reference Committee No. I

Whereas, The American Medical Association is the only structure through which the views and ideas of the practitioner of medicine can be heard; and

Whereas, Today more than ever the medical profession must stand united; and

Whereas, The American Medical Association is our only hope for an effective and meaningful voice in the future development of medical practice in the United States; therefore be it



*Resolved*, That the Oklahoma State Medical Association retain its present policy on membership in the American Medical Association.

*Resolution No. 15*

(APPROVED AS AMENDED)

INTRODUCED BY: William A. Matthey, MD  
SUBJECT: Foreign Medical Graduates  
REFERRED TO: Reference Committee No. III

Whereas, The residency programs of Oklahoma are being flooded by foreign medical graduates; and

Whereas, Our own Oklahoma Health Sciences Center has currently 54 foreign medical graduates, 12 in psychiatry, 8 in anesthesia, 19 in internal medicine, and 12 in pediatrics; and

Whereas, There are a number of other foreign medical graduates in radiology and in other limited specialty residencies in private hospitals in our state; and

Whereas, Almost all of these foreign medical graduates come from developing countries and after completing training, apply for permanent license and set up practice in this country, thus severely aggravating the "Brain drain" from their own country; and

Whereas, It costs as much or more to retrain each of these foreign medical graduates as it would to train a native American; and

Whereas, The language difficulties and cultural background make it extremely unlikely that an economically feasible training program could transform these individuals into family physicians, fully capable of providing primary care to the citizens of Oklahoma; therefore be it

*Resolved*, That the OSMA, through its House of Delegates, recommends that the Legislature of the State of Oklahoma empower the Oklahoma State Board of Medical Examiners to establish limiting rules for the licensure of non-US citizen foreign medical graduates.

*Resolution No. 16*

(APPROVED)

INTRODUCED BY: Marion C. Wagnon, MD,  
William G. Bernhardt, MD and Arnold G. Nelson, MD

SUBJECT: Medical Necessity of Welfare Evaluations

REFERRED TO: Reference Committee No. III

Whereas, The expenditure of State funds for various Welfare Programs is expanding at an

alarming rate; and

Whereas, It is a known fact that there is uncontested waste of these funds; and

Whereas, It would appear that cutbacks are needed to conserve funds for the truly indigent patient; and

Whereas, One prime example is the unnecessary expenditure of funds for medical evaluation of the obviously healthy individuals, seeking State Aid for trivial, non-hindering and sometimes non-existent complaints, under the guise of "rehabilitation;" and

Whereas, Many counselors appear to have lost sight of the original intent of the program (*ie*, to aid the truly handicapped) thereby draining funds from an already overburdened fund; and

Whereas, It would appear that many counselors are sending in far too many people for examinations in an effort to promote and justify their own jobs; therefore be it

*Resolved*, That the OSMA go on record as being opposed to the waste of these funds, and recommends to the State Department of Vocational Rehabilitation that an immediate re-evaluation program be instituted among its employees, especially the school counselors, informing them of the necessity of making an appointment for a student when indeed there is a disability existing; and be it further

*Resolved*, That a copy of this resolution be sent to the Director of the Department of Institutions, Social and Rehabilitative Services and other agencies as deemed necessary by the OSMA.

*Resolution No. 17*

(DISAPPROVED)

INTRODUCED BY: William A. Matthey, MD  
SUBJECT: Maldistribution of Physicians  
REFERRED TO: Reference Committee No. III

Whereas, There continues to exist a crippling shortage of physicians who are well-trained to provide family health care to the citizens of Oklahoma, especially those in rural areas; and

Whereas, Many, perhaps a majority, of the undergraduate students in our medical school express a desire to enter family practice; and

Whereas, Those in charge of providing undergraduate and postgraduate medical training in our state, while giving lip service to the need for family physicians for years past, have as yet provided for only a token training program for same; and

Whereas, Recognizing there is a problem of maldistribution of physicians in our State, and



that there truly are too few family physicians in comparison to the number of specialists; therefore be it

*Resolved*, That the OSMA recommends to the Oklahoma Legislature that beginning with the 1975 residency program, at least 50% of all residents in training be in Family Practice Programs, and that this percentage continue until such a time as it shall become apparent to the Legislature, and the OSMA House of Delegates, that the problem of physician distribution has been solved; and be it further

*Resolved*, That the OSMA, through its House of Delegates, requests that the Oklahoma State Legislature earmark funds appropriated to the OU College of Medicine for the support of Family Physician residency programs as is necessary to relieve the problem of maldistribution of physicians.

*Resolution No. 19*  
(APPROVED)

INTRODUCED BY: Committee On Planning  
SUBJECT: Appreciation For Russell B. Roth,  
MD, President of the American Medical Association

REFERRED TO: Reference Committee No. I

Whereas, Russell B. Roth, MD, Erie, Pennsylvania, has served the medical profession for many years in various important capacities of leadership, most currently as our distinguished, effective and tireless President of the American Medical Association; and

Whereas, Doctor Roth, despite onerous pressures of a national nature, has graced Oklahoma in recent years with repeated visits in his efforts to keep local physicians abreast of current national developments and to seek the views of his constituents; therefore be it

*Resolved*, That the House of Delegates of the Oklahoma State Medical Association pays tribute to Russell B. Roth, MD, President of the American Medical Association, a rare individual who for many years has placed the needs of his profession above personal sacrifice.

*Resolution No. 20*  
(APPROVED AS AMENDED)

INTRODUCED BY: Committee On Planning  
SUBJECT: Physician's Bill of Rights

REFERRED TO: Reference Committee No. II

Whereas, The Illinois State Medical Society is to be complimented for adopting a "Physician's Bill of Rights" suitable for the use of physicians everywhere, to wit:

"1. We support the goal of making available

high quality health care to all people. However, we vigorously oppose employing any means to attain this goal which would compromise the patient's freedom of choice or the physician's right to care for his patients in the manner which his training, experience and judgment dictate to be most effective.

"2. We believe physicians, as professionals, should be allowed to use their knowledge and training for the benefit of all people without government interference and harassment or relegation to the status of government employees.

"3. We reject as a matter of principle the arbitrary development of compensation guidelines for physicians' services by government and insurance companies without prior participation and approval.

"4. We reject as a matter of principle all formulas for compensation of physicians' services not based upon usual, customary, and reasonable fee concepts.

"5. As part of their responsibility to the policyholder and to the public, insurance companies and others providing coverage for medical care should specify in clear and understandable language all benefit limitations.

"6. We reject as a matter of principle insurance companies and others providing medical service coverage implying to policyholders that physicians' charges are excessive.

"7. If an insurance company questions a physician's charges, its medical director or another qualified professional should attempt to resolve the problem by contacting the physician. If they are unable to reach an agreement, the company should present its complaint to the local medical society's peer review committee.

"8. We reject discrimination in physicians' compensation for similar services based solely upon geographic location. We contend that this discourages physicians from establishing practices in rural and other areas already severely affected by a maldistribution of the physician population.

"9. Governing boards and hospitals authorities will not be permitted to unilaterally develop bylaws governing the conduct of medical staffs without the participation and formal approval of the staffs involved. Such action will result in prompt counter action, beginning with an appeal to the Joint Commission on Hospital Accreditation, legal or other steps appropriate to the situation.

"10. Only licensed physicians and dentists approved by the medical staff shall be authorized to admit patients or discharge them



from hospitals and other facilities.

"11. Complaints by patients regarding the quality and manner of care rendered by a physician should be made in writing, notarized, and submitted to the physician's local county medical society. Patients should be informed that it may be necessary to confront the accused during review proceedings.

"12. Unauthorized substitution of prescribed items will be viewed by physicians as the illegal practice of medicine and will be met with counter action, legal or otherwise as the situation warrants;

*"Resolved*, That this Bill of Rights becomes effective upon adoption and implementation will, if necessary, include court action."

*Resolution No. 21*  
(APPROVED AS AMENDED)

INTRODUCED BY: The Oklahoma County Medical Society

SUBJECT: Hospital Staff Privileges

REFERRED TO: Reference Committee No. II

Whereas, the medical profession has traditionally opposed any requirement to pay to be on the staff of a hospital; and

Whereas, failure to pay arbitrary staff dues would be cause for suspension of privileges and use of the hospital; and

Whereas, such requirements would be a very undesirable principle in Hospital Staff Rules and Regulations; therefore be it

Resolved, that the Oklahoma State Medical Association opposes any requirement to pay for staff privileges in any hospital except for dues that are voted and administered exclusively by the medical staff.

*Resolution No. 22*  
(APPROVED)

INTRODUCED BY: The Oklahoma County Medical Society

SUBJECT: Health Insurance for Newborn

REFERRED TO: Reference Committee No. I

Whereas, Every individual has the right to insurance coverage from the time of birth; and

Whereas, Young parents have the right to purchase insurance for newborn coverage to prevent the large financial burdens incurred when children are born with serious medical problems; therefore be it

*Resolved*, That the Oklahoma State Medical Association supports the Model Newborn Chil-

dren Bill as follows:

"All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

"The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

"If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continued beyond such 31-day period.

"The requirements of this act shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than 120 days after the effective date of the act."

*Resolution No. 23*  
(APPROVED AS AMENDED)

INTRODUCED BY: M. Joe Crosthwait, MD

SUBJECT: Protection of Patient's Health

REFERRED TO: Reference Committee No. II

Whereas, Section 249-F of Public Law 92-603, commonly known as the PSRO Amendment, will limit the free exercise of judgment in the care of patients, substituting instead a system based on treatment of diseases rather than people; and

Whereas, PSRO will destroy the confidential relationship and mutual responsibility between the patient and his physician, the basic foundation of the Doctor-Patient relationship; and

Whereas, PSRO is the bureaucrat's answer to the problems of the ill-conceived Medicare-Medicaid laws which increase rather than decrease the cost of medical care; and

Whereas, PSRO gives broad powers of control to the Secretary of HEW over the practice of medicine and in the manner in which medical services are provided, resulting in a rationing of health care; and



Whereas, PSRO legislation is primarily focused at cost control at the expense of the rights and freedom of the patient and doctor; and

Whereas, PSRO will deprive the American people of their rights under the First, Fourth, Fifth, Seventh and Ninth Amendments of the Constitution; and

Whereas, It is the duty and obligation of the physicians of America to protect the health and health care of their patients whether it be in the office, hospital or political arena; and

Whereas, It is the duty and obligation of physicians to actively support or oppose, with whatever means necessary, any procedure, condition, or law which is a threat to their patients' health; and

Whereas, PL 92-603 is considered by most responsible physicians to be incompatible with continued protection of the health of their patients; therefore be it

*Resolved*, That the Oklahoma State Medical Association, its component associations, societies and individual physicians will oppose this dangerous law with whatever means necessary, and will work for the repeal of this dangerous legislation; and be it further

*Resolved*, That in the event this dangerous legislation is not repealed or modified in such a way as to protect the health of the American people, physicians, as caretakers of the health of the American people shall then consider a position of non-participation.

#### *Resolution No. 24*

*(APPROVED)*

SUBMITTED BY: C. Riley Strong, MD

SUBJECT: Appreciation of Thomas C. Points, MD

REFERRED TO: Reference Committee No. I

*Resolved*, In appreciation of THOMAS C. POINTS, MD for twelve years of dedicated service to his profession as alternate delegate to the American Medical Association, the House of Delegates of the Oklahoma State Medical Association pays grateful tribute to a physician who has represented his Oklahoma colleagues in an exemplary manner from 1961 through 1973.

#### *Resolution No. 25*

*(APPROVED)*

INTRODUCED BY: The Oklahoma Academy of Family Physicians

SUBJECT: Recognition and Appreciation for James G. Price, MD, President of The Ameri-

can Academy of Family Physicians

REFERRED TO: Reference Committee No. I

Whereas, James G. Price, MD of Brush, Colorado, presently serving as President of The American Academy of Family Physicians, having served previously in numerous areas of responsibility for the American Academy of Family Physicians; and

Whereas, despite the numerous demands placed upon Doctor Price for appearances across the nation as a spokesman for the Family Physicians, as well as the demands placed upon him in his own private practice of medicine; and

Whereas, Doctor Price has made himself available for the entire session of the Oklahoma Medical Summit to help enhance the success of the meeting; therefore be it

*Resolved*, That the House of Delegates of the Oklahoma State Medical Association pays tribute to Doctor James G. Price as President of The American Academy of Family Physicians as an outstanding physician of national prominence who places service above self.

#### *Resolution No. 26*

*(DISAPPROVED)*

INTRODUCED BY: Comanche-Cotton-Tillman County Medical Society

SUBJECT: Medical College Admissions

REFERRED TO: Reference Committee No. III

Whereas, It has been a documented experience that medical school applicants from rural areas of Oklahoma have experienced a far lesser acceptance rate per population than major urban areas have experienced; and

Whereas, There exists a rapidly expanding medical manpower shortage in these rural areas of Oklahoma; therefore be it

*Resolved*, That the Oklahoma State Medical Association petition and request that the College of Medicine return to the policy of assigning a quota for admissions to all geographic areas of the state, according to population and adheres to this rigidly, providing that the applicants from these areas present qualifications to study medicine. With this accomplished, it is felt that the medical school enrollment will adequately represent all of the state equally; and be it further.

*Resolved*, That each geographical area be represented equally according to population on the Admissions Committee for the University of Oklahoma College of Medicine.

#### *Resolution No. 27*

*(DISAPPROVED)*



INTRODUCED BY: Arnold G. Nelson, MD  
SUBJECT: Medical Legislation  
REFERRED TO: Reference Committee No. II

Whereas, the members of the Oklahoma State Medical Association have a great interest in legislation in Oklahoma, and

Whereas, medical legislation in Oklahoma, has increased in quantity by leaps and bounds, affecting the medical care of all Oklahomans, and

Whereas, the work of our Legislative Committee is carried on by only a few dedicated individuals, particularly, the Chairman of the Legislative Committee and by our Associate Executive Director assigned as a lobbyist during the legislative session, along with his many other duties; and

Whereas, we have only two physicians and a very few other closely related individuals, actually in the legislature; and

Whereas, our Oklahoma State Medical Association has during recent sessions lost some important legislative actions;

*Resolved*, That the Oklahoma State Medical Association be directed to employ another lobbyist to work with our present staff man. The new lobbyist would be employed only during the legislative session, and he would devote all of his time and efforts to lobbying in behalf of the Oklahoma State Medical Association. This should be a man well known in the legislature and with lots of friends there;

*Resolved* that the Legislative Committee be reorganized to involve many more physicians who can have close liaison with every legislator in the state and be organized so that when we need more physicians directly in the galleries of the legislature they will be available;

*Resolved* that more Oklahoma State Medical Association members be encouraged to run for legislative office. ☐

## WE NEED YOU!

If the Oklahoma Medical Political Action Committee (OMPAC) is going to be adequately prepared to support candidates of your choice in 1974, your \$20 membership or \$100 sustaining membership contribution is crucial.

OMPAC is your voluntary, bi-partisan political action arm. Your dollars are used to support Oklahoma candidates for federal and state office. The more dollars OMPAC has to spend, the more legislators there will be who understand medicine's legislative concerns and who will listen to your views and those of your colleagues.

Join us in 1974 — we can go a long way — TOGETHER.

If you have not already joined, send your check for either a \$100 sustaining membership or \$20 for a regular membership to:

**OMPAC**

P.O. Box 73541  
Oklahoma City, Oklahoma 73107



## *A Bit Irrational*

If you're somewhat sickened by the interminable flow of words about PSRO, spare yourself the pain of reading this and turn the page. This piece is written by me, largely for me. It is pure auto-psychotherapy . . . ventilation . . . catharsis . . . exorcism. I have no alternative, no freedom of choice, no power to resist the compulsion to scream, cry, laugh or write about the calamity called PSRO. And the AMA endorsement of it is, very literally, totally beyond my comprehension; simply beyond believing.

My ineloquent vocabulary tortures me with its poverty. It provides me with no words which are grand enough, or powerful enough or emphatic enough to describe, even approximately, my reaction to the shotgun wedding of the AMA and the bureaucracy's pet monster, PSRO.

When the decision-makers in the AMA decided it is better to commit suicide than to submit to execution, they didn't fully understand what it is they are going to be allowed to do: They are being given an opportunity to design the weapon with which they will be tortured to death. It will not be a clean, quick, painless and merciful killing. It will be a lynching without a rope; a dismemberment by the mob. And each furious assailant will claim, with some contrived justification, that the victim himself incited the violence and participated in his own butchering.

Such an allegory is not distorted or exaggerated. It is pitifully appropriate and starkly realistic, as a brief review of the facts will prove.

A group of mature, intelligent and presumably sophisticated adults representing the AMA agreed to assume the responsibility and the liability for implementing and operating a cumbersome, expensive, improbable scheme

which, in effect, will become another bureau of the federal government. As such, it will be totally and absolutely controlled by a politically appointed, power-wielding, fund-controlling, authoritarian and at-times-dictatorial bureaucrat. Every member of the AMA House of Delegates knows this, and more.

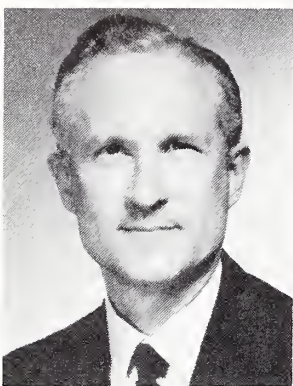
He knows the sorry record of every politically inspired, government-designed, bureaucrat-operated venture. He cannot name an instance where one functioned effectively, performed efficiently, escaped improper political influence and was not perverted by its own ambitious bureaucrats. He knows with doubtless certainty that every such program, without exception, grows to monstrous proportions, consumes an ever-increasing river of money and eventually becomes unmanageable and uncontrollable.

Finally, everyone who has had even the most casual experience with the Medicare or Medicaid programs knows that, once the unilateral "contract" is arranged, the costs begin to rise as the benefits steadily decline. Then the providers of care are accused of fraud, overcharging and greed and are held up to public scorn as the ones responsible for every deficiency and every shortcoming of the whole hair-brained scheme.

It is really impossible to believe that our well-intentioned representatives, fully aware of these facts, could agree to expand our role in such a futile effort, fraught with so much risk. Of course they say they had no choice. So they chose to be responsible for implementing the idealistic, complex, extravagant, controversial boondoggle known as PSRO.

If such a choice strikes you as a bit insane or causes you to scream or laugh or cry, pick up your pen and write. It's helped me a lot.  
*MRJ*





The residents of Oklahoma have a serious problem that literally begs for immediate solution, yet I am quite certain that all too few recognize its importance.

I refer to the financial plight of our medical school, University Hospital and Health Sciences Center in Oklahoma City. These institutions comprise some of this state's greatest assets. Instead of being neglected and disadvantaged they should be carefully nurtured and generously developed. No other investment could produce greater returns. For some rather obscure reasons the medical center has been treated as a stepchild financially and its great potential ignored. Just at a time when the student body of the medical school has been enlarged to supply expanded primary care throughout the state, its funds have been further curtailed. Several capable department heads, being faced with a similar state of affairs year after year, have despaired, resigned and gone to medical schools in other states where funding was more dependable and they could concentrate on professional matters free of fiscal worries.

I can only assume that our legislators cannot possibly realize the seriousness of the situation. Perhaps this is due to inadequate communication. Perhaps input of pertinent information as regards both needs and merits has been lacking, or at least insufficient or unclear. In any event, serious, possibly irrevocable, harm is being done. Our state association must, and I pledge that it will, assist the dedicated faculty still remaining in apprising our good legislators of the importance of correcting the situation. While it may have been erroneously assumed that the faculty in Oklahoma City was possibly self-serving in seeking funds, certainly the practicing physicians of the state comprising OSMA can only be considered interested in good

medicine that is widely distributed to as many areas of the state as is possible. Certainly there can be no self-aggrandizement when we are supporting a plan to produce more well-trained doctors into our own areas of practice.

This state cannot afford to let its medical center deteriorate. It is indeed ironical that with many contending enough doctors are not being produced that obstacles are now being placed in the way of correcting that very situation.

There must be a complete revelation of all the information that our legislators need. And our legislators must surely and carefully consider the information and meet a budget that is proper. Certainly they will realize the faculty as both dedicated and altruistic. There is not a one who could not earn more in private practice. I have faith that our legislature will meet its obligations when provided clear and complete information as to the financial needs. Distrust and lack of mutual understanding can damage the future of the medical center and of the state at one in the same time.

Already we have been the source of some ridicule, to the extent that faculty replacements and applicants have heard of the existing problems and taken positions elsewhere. We have now seen the Dean of the medical school resign, the sixth important faculty member to do so. It has been found that harrassment and challenges to their integrity have been factors even more important in causing resignations than has the inadequacy of funds.

Now then, let us turn this thing around. Each doctor in each county must contact his representative and senator and explain the seriousness of this situation. Our medical center must be saved. Our state medical association has embarked on a statewide program to do just that.

*J. L. Richardson, M.D.*



# The Epidemiology of Cancer of the Buccal Cavity and Pharynx in Oklahoma

CHARLES F. BOOZE, MA  
NABIH R. ASAL, PhD

*Unusual clustering of excess mortality  
from cancer of the buccal cavity and  
pharynx in certain geographic areas of the state  
is suggestive of common etiology.*

## INTRODUCTION

Nationwide statistics on cancer of the buccal cavity and pharynx show that about 7,600 people in the United States died during 1973 from cancer originating at these sites. Oklahoma's contribution to this total is estimated to be about 80 deaths.<sup>13</sup>

International data published by Segi *et al.*<sup>10</sup> ranks the United States 8 and 12 for oral cancer as a cause of death for males and females respectively. Countries in the top five, with regard to age-adjusted death rates per 100,000 population included Hong Kong, France, Puerto Rico, Switzerland, and Taiwan; while Nicaragua, El Salvador, Japan, Greece, and Israel reflect low oral cancer mortality rates.

From the Department of Biostatistics and Epidemiology, College of Health and Allied Health Professions. The University of Oklahoma Health Sciences Center.

Time trends in age-adjusted mortality rates for oral cancer in the United States show slight fluctuations since the early fifties with no overall change for either sex. However, black male rates have increased somewhat since the early fifties.<sup>2, 10</sup>

Males experience higher morbidity and mortality rates for oral cancer than females. The sex difference is a consistent observation in international data with very few exceptions. Whites have higher morbidity and mortality rates than nonwhites. Older ages are more frequently affected regardless of sex or race.<sup>2, 10, 13</sup> A marked deficit of oral cancer occurrence is found among Jews.<sup>4, 12</sup> Oral cancer has been shown to occur more frequently in rural areas and among farming and other outdoor occupations.<sup>3, 6, 8</sup> Etiologically, cancer of the buccal cavity and pharynx has been associated with dietary deficiencies, poor oral hygiene, and prevalent use of irritants such as tobacco and/or alcohol.<sup>1, 3, 4, 6, 8, 11, 12</sup> Cirrhosis of the liver has repeatedly been found to be associated with cancer of the mouth and pharynx.<sup>3, 4, 5, 6</sup>

Some studies have been concerned with special groups subjected to unique exposure factors, eg, betel-chewing among Natal Indians as an etiologic factor, with findings which generally support the irritant hypothesis.<sup>9</sup> Various



findings have been reported dealing with urban-rural differences, socioeconomic factors, marital status, etc, many of which are inconclusive or inconsistent due to small case numbers and other methodological problems.

Cancer of the buccal cavity and pharynx does not kill many people when measured absolutely or proportionately. As a percent of all cancer deaths, oral cancer contributes about two to three percent. However, so many deaths from a site so easily observable provides impetus for more intensive educational and case-finding efforts, particularly in view of the favorable prognosis for survival when detected early.

This report has been prepared to document the descriptive epidemiology of cancer of the buccal cavity and pharynx in Oklahoma for the years 1950-1954 and 1956-1970 to appraise time trends, age, sex, race experience and geographic variation in an attempt to better define those who should be the recipients of more intensive educational and case-finding efforts. Hopefully, these findings will also stimulate further etiologic hypotheses and research concerning this disease.

#### METHOD OF PROCEDURE

Raw data for the analyses which follows were obtained from IBM cards maintained by the Department of Biostatistics and Epidemiology, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma. These mortality data were originally obtained from death certificates filed in the office of Vital Statistics, Oklahoma State Department of Health. Information from all resident death certificates filed between 1950 and 1970 indicating cancer of the buccal cavity and pharynx (international statistical classification codes 140-149) as the underlying cause of death were transferred to IBM cards for tabulation purposes. Data for calendar year 1955 were essentially lost due to conversion problems and are, therefore, not included in the analyses. Available information includes:

Age in years, sex, race, year of death, marital status (1950-1954 only), county of death and of residence, occupation (1950-1954 only) and cause of death (ISC code 140-149).

The international statistical classification codes (ISC) 140-149 included the following specific sites:

140 — Malignant Neoplasm of Lip— excludes malignant neoplasm of skin of lip

141—Malignant Neoplasm of Tongue

142—Malignant Neoplasm of Salivary Gland

143—Malignant Neoplasm of Gum

144—Malignant Neoplasm of Floor of Mouth

145—Malignant Neoplasm of other and unspecified Parts of Mouth

146—Malignant Neoplasm of Oropharynx

147—Malignant Neoplasm of Nasopharynx

148—Malignant Neoplasm of Hypopharynx

149—Malignant Neoplasm of Pharynx, unspecified

Cause of death data were combined for analysis purposes due to small numbers. Data were analyzed according to sex, race, and year of death for purposes of appraising overall secular trends by sex and race. Annual death rates by sex for the total population, as well as average annual death rates for the four five-year periods (1950-1954, 1956-1960, 1961-1965 and 1966-1970), were also prepared to provide annual and five-year time trend analysis.

Death rates by age, sex, and race for the twenty-year period are presented to provide a basis for analysis of these epidemiologic variables, and their time trends. The 1960 white male population for the state of Oklahoma was used to arrive at age-adjusted death rates (direct method) for each of the sex-race groups.

A major thrust of this study is concerned with possible geographic clustering of high mortality from this disease. Therefore, based on the mortality experience of the total Oklahoma population from cancer of the buccal cavity and pharynx over the twenty-year period studied, expected cancer deaths for this site were computed for each county based upon county population data. A standard mortality ratio was

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then tabulated for each county using observed deaths for the county as the numerator and expected deaths as the denominator. This ratio was multiplied by 100 to obtain the standard mortality ratio for the county.

Obviously, if observed and expected deaths were approximately equal, the standard mortality ratio would be around 100. If, however, observed deaths for a county were higher than expected, the standard mortality ratio would reflect the excess deaths as a percent increase above expected. Likewise, an observed to expected ratio of less than 100 would indicate low buccal cavity and pharynx mortality for the county. The standard mortality ratios were tested for significance using the test of Bailar and Ederer.<sup>14</sup>

In an attempt to define the urban-rural relationship of mortality for this site, comparisons based on county population size and standard mortality ratios were analyzed.

RESULTS AND DISCUSSION

Buccal cavity and pharynx cancer deaths by race, sex, year, and rates per 100,000 for the total population by year from 1950-1970 (less 1955) are presented in Table 1. Average annual death rates for the four five-year periods and combination of years are also presented. No surprises are apparent from Table 1 and findings are as one would expect based on national trends. Very little fluctuation by year, by five-year periods, or over the entire twenty-year

Table 1  
BUCCAL CAVITY AND PHARYNX CANCER DEATHS BY SEX,  
RACE, AND YEAR WITH DEATH RATES FOR THE TOTAL  
POPULATION BY SEX AND YEAR — OKLAHOMA 1950-54, 56-70

Year of Death	White		Black		Indian*		Total (Deaths)		Total (Rates per 100,000)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1950	58	13	2	—	1	—	61	13	5.5	1.2
51	44	13	2	1	1	—	47	14	4.2	1.2
52	35	16	6	2	1	—	42	18	3.7	1.6
53	43	15	5	5	—	—	48	20	4.3	1.8
54	54	17	—	—	—	1	54	18	4.8	1.6
1950-54	234	74	15	8	3	1	252	83	4.5**	1.5**
1956	44	18	2	1	—	—	46	19	4.0	1.6
57	64	18	6	1	2	—	72	19	6.3	1.6
58	44	15	2	—	—	1	46	16	4.0	1.4
59	49	12	6	—	1	—	56	12	4.9	1.0
60	51	12	1	2	1	1	53	15	4.6	1.3
1956-60	252	75	17	4	4	2	273	81	4.8**	1.4**
1961	45	19	1	1	2	—	48	20	4.2	1.7
62	48	29	3	—	1	—	52	29	4.5	2.4
63	42	19	1	2	—	—	43	21	3.6	1.7
64	51	20	6	1	1	—	58	21	4.9	1.7
65	59	22	3	1	1	2	63	25	5.3	2.0
1961-65	245	109	14	5	5	2	264	116	4.5**	1.9**
1966	57	19	2	—	1	—	60	19	5.0	1.5
67	49	21	1	—	—	—	50	21	4.1	1.6
68	55	28	2	1	1	—	58	29	4.7	2.3
69	56	17	3	—	1	—	60	17	4.9	1.3
70	63	29	2	1	3	1	68	31	5.5	2.4
1966-70	280	114	10	2	6	1	296	117	4.8**	1.8**
1950-70 (less '55)	1,011	372	56	19	18	6	1,085	397	4.6**	1.6**
1956-70	777	298	41	11	15	5	833	314	4.7**	1.7**

\*Two with sex unknown during 1950-54.

\*\*Average annual rate.



period studied is present for either males or females. The male/female ratio overall is 2.7:1 and a similar ratio is observed by race separately. Whites account for 93% of total deaths during the twenty-year period. Blacks and Indians account for 5% and 2% respectively. Of the total population, blacks and Indians represent 6.6% and 2.7%. Blacks and Indians, therefore, experienced slightly less mortality than expected based on population representation. Low cancer mortality among Indians is not, however, unique to this site.

Age-sex-race-specific death rates, as well as age-adjusted death rates, for buccal cavity and pharynx cancer are presented in Table 2 for each five-year period. Very few deaths occur at younger age intervals and data were combined for ages less than 35 years. Without exception, age-sex specific death rates increase dramatically with age, with highest rates universally occurring at ages above 74 years for whites and nonwhite females only. The rates for nonwhite males are an exception in that no obvious trend is indicated. This observation for non-white males may be a reflection of overall decreased longevity and competing risks recognized for nonwhites (principally blacks). Certainly, the

small numbers for some cells make results inconclusive regarding any definite patterns.

As expected, age-adjusted death rates are highest for white males and reflect excess-male to female mortality. No time trends are apparent in age-adjusted mortality rates for any group except nonwhite males. This finding would be consistent with national trends for black males.<sup>2</sup>

Figure 1 shows the geographic distribution of mortality expressed in terms of standard mortality ratios. A standard mortality ratio above 100 reflects an excess of observed to expected deaths for that county, had statewide rates prevailed. Standard mortality ratios below 100 reflect favorable mortality experience for the county. A ratio of approximately 100 indicates expected mortality was realized.

Examination of Figure 1 reveals that standard mortality ratios in excess of 100 may be found in every sector of the state. Likewise, values below 100 may be found in all major sectors. However, closer examination reveals that a high percentage of eastern and southeastern counties show standard mortality ratios in excess of 100. Low standard mortality ratios occur in the northwest and panhandle sectors of the state. Other sections show an intermittent pattern of greater and less than 100.

Table 2

Age-Sex-Race-Specific Death Rates for Buccal  
Cavity and Pharynx Cancer  
Oklahoma: 1950-1954, 1956-1970  
(Rates per 100,000 Population)

Age	White Male				White Female			
	1950-54	1956-60	1961-65	1966-70	1950-54	1956-60	1961-65	1966-70
<35	0.3	0.2	0.5	1.0	0.2	0.2	0.5	0.2
35-44	2.2	7.6	3.1	4.0	1.4	2.1	2.2	0.8
45-54	20.2	23.5	28.3	28.8	9.4	4.8	6.1	11.4
55-64	54.1	62.2	61.9	61.3	11.1	13.0	8.3	18.4
65-74	108.0	110.0	100.2	119.7	39.6	25.3	42.2	28.0
>74	289.4	213.6	183.0	201.4	75.0	82.9	94.5	81.0
A.A.D.R.	25.0	24.2	22.6	25.0	7.6	6.8	8.1	7.9

Age	Non-White Male				Non-White Female			
	1950-54	1956-60	1961-65	1966-70	1950-54	1956-60	1961-65	1966-70
<35	1.0	0.0	1.4	0.0	0.0	1.4	0.0	0.0
35-44	0.0	0.0	10.1	0.0	0.0	0.0	0.0	0.0
45-54	19.9	19.9	50.0	37.2	27.5	0.0	8.5	0.0
55-64	79.9	85.0	33.9	52.2	13.4	0.0	20.1	8.6
65-74	69.1	82.3	94.9	80.4	34.2	15.7	14.7	0.0
>74	36.2	90.9	80.0	24.1	236.5	119.1	74.2	37.8
A.A.D.R.	16.4	18.6	19.8	23.0	15.1	6.2	5.4	2.2



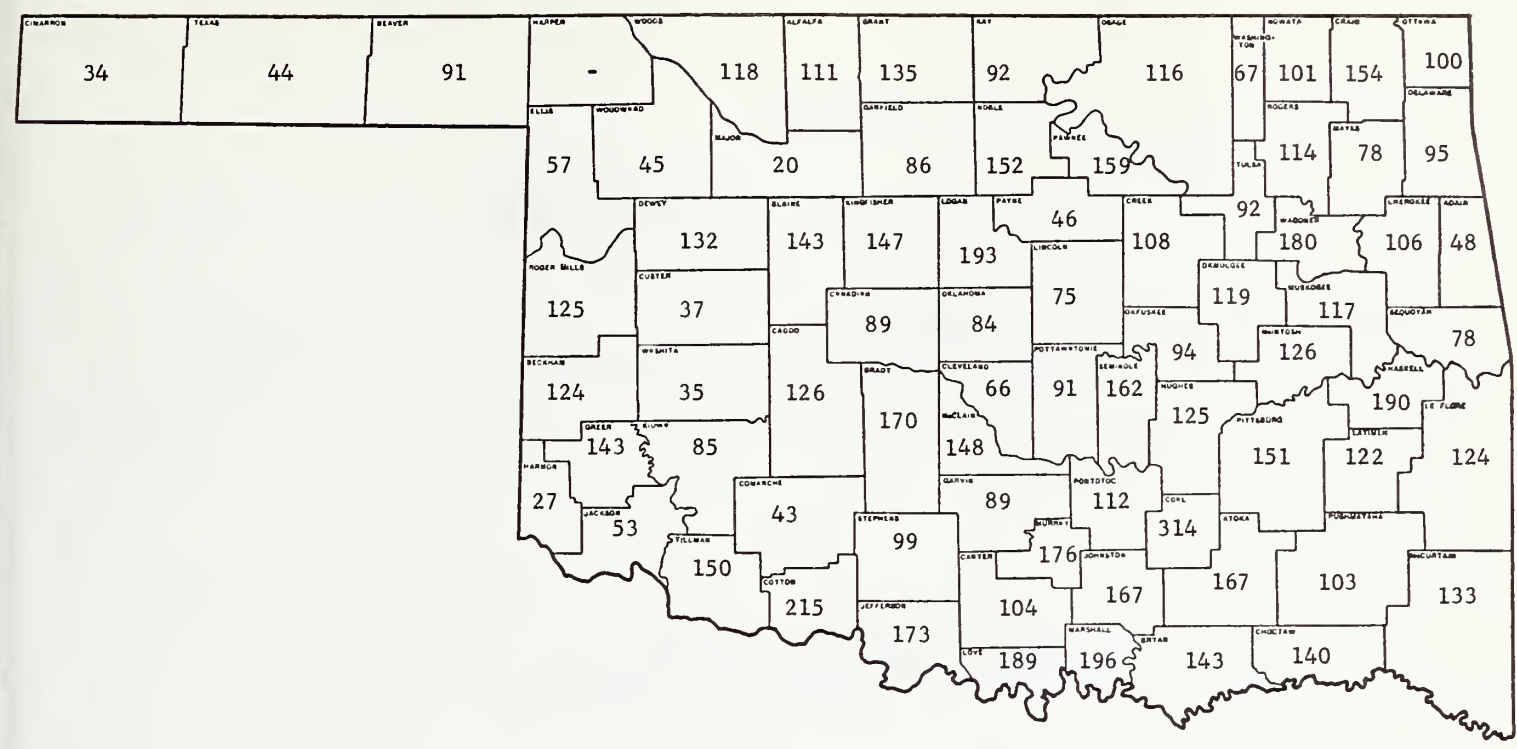


Figure 1. Standard Mortality Ratios of Buccal Cavity and Pharynx Cancer In Oklahoma By County, 1950-1970 (less 1955).

Table 3 shows the twelve Oklahoma counties reporting significant ( $p < .05$  or  $p < .01$ ) standard mortality ratios. Comanche, Custer, Payne, Oklahoma and Washita Counties experienced significantly lower deaths from cancer of the buccal cavity and pharynx than was expected; whereas, the counties of Coal, Cotton, Grady, Logan, Pittsburg, Seminole and

Wagoner experienced greater mortality than was expected, which was found to be statistically significant.

Interesting, in terms of urban-rural observations, is that eight of the ten Oklahoma counties with populations in excess of 40,000 showed standard mortality ratios less than 100, ie, Cleveland, Comanche, Garfield, Kay, Oklahoma, Pottawatomie, Tulsa, and Washington had standard mortality ratios less than 100. Only Creek and Muskogee counties had standard mortality ratios above 100 and both might be considered of borderline importance (108 and 117 respectively). Of the remaining sixty-seven counties with population less than 40,000 forty-four had standard mortality ratios greater than 100 (66%).

While these findings are in keeping with previously observed trends for higher rates among rural populations, the obvious clustering of excess mortality in some geographic areas is deserving of further study concerning other potential etiologic factors common to these areas. Otherwise, findings in the Oklahoma data for this time period do not deviate from available epidemiologic data for cancer of the buccal cavity and pharynx. However, limited mortality data for Indians are suggestive of a somewhat decreased mortality among Indians for cancer of the buccal cavity and pharynx.

Undoubtedly of greater importance from a public health standpoint, geographic areas and age groups among Oklahomans have been iden-

Table 3

Observed and Expected Cancer of the Buccal Cavity and Pharynx in Counties Reporting Significant Standard Mortality Ratios, Oklahoma

County	Number of Deaths Expected	Standard Mortality Ratio Observed	
Coal	3.5	11	314**
Comanche	57.8	25	43**
Cotton	5.1	11	215*
Custer	13.4	5	57*
Grady	18.8	32	170**
Logan	11.9	23	193**
Oklahoma	280.0	236	84**
Payne	28.2	13	46*
Pittsburg	21.9	33	151*
Seminole	17.9	29	162*
Wagoner	10.0	18	180*
Washita	11.5	4	35*
DT			

\* Significant at  $p < .05$   
\*\* Significant at  $p < .01$



tified which could lead to increased educational and case-finding efforts.

#### SUMMARY

Mortality data for cancer of the buccal cavity and pharynx among Oklahoma residents during the time period 1950-1970 (less 1955) have been analyzed for age, sex, race, geographic, and secular trends. Generally, findings for the Oklahoma data paralleled previously recognized trends with regard to the epidemiologic variables under consideration. Limited data for Oklahoma Indians are suggestive of somewhat decreased mortality from this cause; however, small numbers preclude definitive statements. While consistent with urban-rural expectations, unusual clustering of excess mortality in certain geographic areas of the state are deserving of further study regarding potential common etiologic factors.

Populations have been identified for in-

creased educational and case-finding efforts.

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## Doctors Save Lives by Telephone

JOHN G. BELLOWS, MD, PhD

*Person-to-person consultation with top experts in any field and the latest information on any medical subject are now available within minutes through MediPhone, a lifesaving nationwide physicians' telephone service.*

MediPhone, an innovative new medical information and consultation service, is helping the nation's doctors save lives and treat patients more effectively. Twenty-four hours a day, seven days a week, MediPhone responds to calls from doctors who are confronted with perplexing medical problems or patients who have failed to respond to treatment.

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The Chicago-based MediPhone program demonstrates its life-saving potential almost daily. Recently a doctor in a small northern Illinois community was called to treat a patient

From the University of Health Sciences—The Chicago Medical School

who had been bitten by the dangerous brown recluse spider. This species has only recently migrated from the South to the northern parts of the country. It requires a minimal temperature of 40 ° F to survive. Thus, in colder climates it may be found in such places as closets and basements. The physician who called MediPhone had never encountered a similar case and requested information on the treatment of the bite of this poisonous spider. Time was critical; delay would cause much suffering and perhaps even endanger the patient's life.

The attending physician immediately dialed the nationwide MediPhone physicians' consultation service telephone number (312) 782-7888. Moments later he was in consultation with an expert toxicologist at The University of Texas Medical Center in San Antonio. The expert informed the calling doctor that the modern management of the recluse spider bite required a wide excision since the bites are multiple, and the administration of large doses of cortisone. Within hours, the patient had been treated according to the plan outlined by the consultant. The immediate application of these measures undoubtedly saved the patient from a great deal of pain and possible death.

In another emergency, a farmer in Kansas fell off his tractor; while his wife and several farm hands stood helplessly by, a steel blade of the rotary machine severed the farmer's right hand about one inch above the wrist. The farm workers rushed the farmer and his severed hand to the nearby family physician, who in turn called MediPhone. MediPhone connected



the family physician with a surgeon at a nearby university trauma center. The patient was immediately taken to the trauma center where the severed hand was reattached by a plastic surgeon. Two weeks later the patient was able to move his hand and wrist. Although the hand has not yet recovered its sensory functions, complete recovery is still possible.

MediPhone also performs educational and consultative service for non-emergency calls. A doctor in Yuma, Arizona, recently called MediPhone to obtain advice and recommendations from a specialist in lung diseases. For more than a week the doctor had been treating without success the 52-year-old proprietor of a local furniture store. At first the man thought he had a cold, but he developed a symptom complex consisting of 102 ° F temperature, cough, and pain in the chest. X-rays disclosed unfamiliar patches in both lungs. The physician was baffled by the X-rays so he called on MediPhone's resources.

The practitioner learned from MediPhone's lung specialist in New York that the condition was undoubtedly a mycoplasma pneumonia caused by a minute bacterium. Fortunately, the disease responds quickly and favorably to antibiotics such as tetracyclines and erythromycin. The patient responded to the proposed treatment and made a speedy recovery.

MediPhone was originated in 1972 by its director, Dr. John G. Bellows, a Chicago eye specialist. The service is sponsored by the non-profit American Society of Contemporary Medicine and Surgery, a 7,000-member physician organization whose purpose is to disseminate the latest medical information to doctors. Among the leaders of the Society and MediPhone are the chairman, Dr. Morris Fishbein, medical author and former editor of the *Journal of the American Medical Association*, and the

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*Certified by the American Board of Ophthalmology, John Bellows, MD, PhD, is presently Clinical Professor at the Chicago Medical School. Doctor Bellows is a Fellow of the American College of Surgeons and is a member of the American Academy of Ophthalmology and Otolaryngology, the New York Society of Clinical Ophthalmology and is Founder and Director of the American Society of Contemporary Medicine, Surgery and Ophthalmology.*

president, Dr. Michael E. DeBakey, famed heart surgeon. The more than 600 consultants are located in some 60 university medical centers throughout the country. These include deans of medical schools, heads of departments, and outstanding specialists in all fields of medicine and surgery.

The Society and MediPhone are approved by the American Medical Association for continuing medical education. Therefore, the physician who uses MediPhone not only obtains medical information and consultation, but he also receives a certificate for credit hours in continuing medical education.

"Our main motive," Dr. Bellows explains, "is to help doctors practicing in an area where they have difficulty keeping pace with the best and most advanced medical care possible." However, Dr. Bellows emphasizes that the program is not a substitute for the consultant who personally reviews the patient's hospital chart, elicits a medical history, and examines the patient. Rather, it is intended to overcome barriers of distance and allow doctors to consult readily with experts on medical problems that may be unusual and baffling. Frequently the caller has need of information that may not yet have been published; MediPhone can provide physicians with the latest treatments available long before they appear in printed form.

MediPhone is available only to physicians. The charge for a MediPhone consultation is \$25, from which the consultant receives a fee for his services. The charge for the consultation can be included in the patient's bill and may be covered by his health insurance carrier. MediPhone ultimately should help reduce the rising cost of medical care. Doctors who use MediPhone can provide better care for their patients, and better care is usually cost-saving in the long run.

MediPhone, the first and only nationwide physicians' telephone consultation service in operation, recently received a regional development grant from the prestigious Robert Wood Johnson Foundation. This grant will help pay for the administration of MediPhone and make its services better known to physicians. Current plans are to mail individual membership cards to physicians. It is hoped that wider use of MediPhone's resources will enable physicians to administer better health care to the public.

30 North Michigan Avenue, Chicago, Illinois 60602



# A Real Estate Transaction For The Physician and His Children — II

ROBERT W. GADDIS

*A low cost investment for the young physician that will reduce taxes, benefit family members, accomplish estate planning goals, and that will provide a good return on your money.*

## INTRODUCTION

In an earlier issue of *The Journal*,<sup>1</sup> I presented a real estate transaction designed for the physician with older children. This article discusses a similar real estate transaction; however, *this* transaction is targeted toward the younger physician with young children.

In my earlier article, I suggested the physician construct a single-family dwelling unit, using leveraged financing, and then rent the house to one of his children who might be in need of housing. This plan accomplished several results; it: 1) generated tax shelter and good return on investment for the physician, 2) provided good housing, at reasonable rates, for the children, and 3) depending upon the type of disposition modality utilized, fulfilled various estate planning goals.

As with my earlier article, the plan herein discussed utilizes several relatively simple planning concepts which, when properly juxtaposed, will fulfill a multiplicity of planning goals. *This* plan embodies the following elements:

- 1) Utilization of leveraged financing to construct a residential rental unit, preferably a duplex or larger structure.
- 2) Execution of maintenance contract with builder.
- 3) Retention of property until it ceases to pro-

vide tax shelter.

4) Transfer of property to trust to provide for children's college education.

5) Disposition, or retention, depending on estate planning goals.

## CONSTRUCTION OF RESIDENTIAL RENTAL UNIT

The primary reason for utilization of new residential rental construction as the investment vehicle lies in the fact that new residential rental property is one of the only remaining areas where the Internal Revenue Code allows accelerated depreciation.<sup>2</sup> And, as it is the combination of depreciation and interest deductions which generates the tax shelter, it is important to obtain as much depreciation and interest as possible. The depreciation deductions are generated through the availability of accelerated depreciation for new residential rental property, while interest deductions are obtained through utilization of leveraged financing.

When speaking of "leveraged financing," I am referring to a transaction wherein a minimum down payment is utilized, with the balance financed at the lowest rates obtainable for a term of twenty to thirty years. The result of this financing modality, in concert with other tax planning concepts, is the creation of a tax shelter whereunder a tax loss is generated while the investment pays for itself, generating a tax-free profit.<sup>3</sup>

Although the investment yields a paper (and financial) profit, for tax purposes (due to the availability of deductions for interest, depreciation, taxes, insurance and maintenance), the project operates at a loss for a number of years, thereby creating a tax shelter. The tax shelter, the amount of deductions available to offset ordinary income, also creates a savings in the form of income tax reductions. All of these items combined, by way of illustration, resulted in a



12 to 13 percent return in the transaction I discussed in my previous article.<sup>4</sup>

Although such a return is not spectacular, it must be remembered that we are accomplishing various goals other than the actual cash return on the investment.

Before turning to an analysis of the other elements of the transaction, I would like to digress briefly and discuss the role played by creativity and planning in transactions such as the one herein under scrutiny. There are a number of different configurations in which these transactions may be cast, with each configuration determined by the needs and goals of the individuals involved. Thus, eg, two physicians could joint-venture a luxury quadruplex, thereby reducing the entry cost, while maintaining separate interests which they could posture in the form most suitable to their respective needs; or a limited partnership (with a builder-developer as the general partner) could be formed to construct and operate an apartment house. In short, the possibilities are limited only by the imagination of the individuals structuring the transaction; thus, through creativity and planning, it is possible to structure an investment vehicle capable of meeting multi-faceted objectives, and which is capable of accommodating widely differing personalities.

#### MAINTENANCE CONTRACT

The typical response to the harried professional, when confronted with discussion involving rental property investments, is one of: "Who will take care of the maintenance?" The answer, although quite simple, involves some knowledge of the construction trades. The builder is the person to turn to for the maintenance.

Most residential dwelling builders are of the general contractor type; ie, they serve as general contractors, subcontracting out the different phases of the project. Such builders, generally, have few employees and little equipment, relying on "subs" for the bulk of the construction. However, there are very few such builders who do not have at least one full-time handyman in their organization. The handyman will, variously, provide repairs on struc-

tures still under builder's warranty, or he may smooth over rough spots left behind by the "subs." In short, the builder's handyman is a jack-of-all-trades and can provide a broad range of services.

Generally, a builder's projects do not require all the handyman's time. Accordingly, the builder is eager to enter into maintenance agreements whereunder his handyman's time may be more fully utilized. Thus, your builder may also be willing to enter into a maintenance contract on the structure he has constructed for you.

Additionally, the residential builder may also be in a position to provide for the leasing of your property. Thus, by carefully selecting your builder, you will be able to provide for construction, maintenance and leasing, all in the same individual.

The desirability of this arrangement is obvious: Working with only one properly-chosen individual will reduce the amount of your time required to manage the investment.

#### TRANSFER TO TRUST

Depending on the interest rate at which financing is obtained, the investment will start generating a taxable cash flow somewhere around the eighth year after it has been established. This means the tax shelter is lost. Moreover, at that time, the physician will probably have earnings which will place him at, or near, a 50% tax bracket. Under such circumstances, the last thing he needs is more taxable income. Thus, once the tax shelter is lost, the physician must utilize one of the various techniques for diverting the investment income from *his* taxable income.

For purposes of this discussion, I suggest the use of a trust as an income-diverting device and as a means of providing for your children's college education with "cheaper dollars." (Providing a college education after the investment has ceased to furnish a tax shelter is only one of the possibilities for utilization of income-producing property. Thus, eg, the same vehicle could be utilized to provide income for other individuals, or organizations, you are interested in assisting.) Before discussing the trust and tax consequences appertaining thereto, I will explain the term "cheap dollars."

Let's assume that the cost of a year of college is \$5,000.00. This means you have to expend \$5,000.00 in *after-tax* dollars for each year of

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*Robert W. Gaddis received his BA and JD degrees from the University of Oklahoma and his LLM (Taxation) from Southern Methodist University. Mr. Gaddis is affiliated with the Tulsa, Oklahoma, law firm of Jarboe, Keefer and Barrow.*



college for each child you assist in obtaining a college education. The only deduction you obtain for this expenditure is the dependent deduction of \$750.00.<sup>5</sup> The real burden, however, lies in the realization for a 50% bracket taxpayer that he has to earn \$10,000.00 to have left, after taxes, the \$5,000.00 with which to assist his child. Thus, for every dollar given to the child, the taxpayer had to earn two dollars — these are “expensive dollars.”

“Cheaper dollars” may be generated by transferring the income producing property to a trust for the benefit of one of your children, whereunder the income will be taxed to that child. The child will then have funds, which you have made available, with which to meet college expenses. That is, the income is removed from your taxable income, yet you have provided a vehicle that will practically insure your child's college education. Moreover, since the child will be in a low income bracket, very little of the income from the rental unit will be consumed in taxes, resulting in almost a complete pass-through of all the income from the rental unit to your child.

There are two types of trusts which I believe are suitable for the purposes herein discussed. One such trust is the so-called “minor's trust.”<sup>6</sup> The other is the so-called “short term” trust.

The desirability of these two types of trusts lies in the fact that, if properly structured, transfers may be made to these trusts without the donor incurring a gift tax.

Thus, if a minor's trust is established in accordance with the provisions of IRC 2503(c), the donor may avail himself of the \$3,000/donee annual exclusion. This means a husband and wife may make \$6,000.00 in tax-free gifts each year to such a trust for the benefit of one of their children. If the value of the rental unit you wish to transfer to the trust is more than \$6,000.00, simply make annual transfers of a \$6,000.00 interest in the unit until you have completely transferred your entire interest.

The only drawback to the minor's trust lies in the fact that the trust corpus and accumulated income (*ie*, whatever is being held in the trust) must pass irrevocably to the donee upon his attaining the age of 21.<sup>7</sup> This can generate pragmatic difficulties, especially where the trust is being created while the child is still in his pre-teens. Thus, it is necessary to make the assumption that the child will mature, with a

motivation toward obtaining a college education. Nonetheless, it is still possible for the parents to maintain some degree of control over the corpus after the child attains age 21, because the child knows there is “more where that came from” if he maintains amicable relations with his parents. This is a somewhat cold and indifferent approach to the problem; however, the efficacy has proven to be somewhat more than theoretical. Thus, although the child will have unfettered title to the property at age 21, the child, it is assumed, will remain responsive to the parents' wishes in regard to this property.

The short-term trust, if required to distribute all income during the year in which such income is earned, may also be established without the expense of a gift tax.<sup>8</sup> Under a short-term trust, the income will not be taxed to the grantor (the person establishing the trust) if: 1) The trust is irrevocable,<sup>9</sup> 2) the grantor retains no interest in the property which will revert to him sooner than 10 years from the date the trust is created,<sup>10</sup> 3) the grantor relinquishes all control and dominion over the property,<sup>11</sup> and 4) the grantor does not retain the right to have income distributed for the benefit of himself or his wife.<sup>12</sup>

Despite the seeming limitations on the short-term trust, it provides much more flexibility than the minor's trust, and is the “trust of choice,” in this writer's opinion, for the situation herein discussed. *Although* the grantor must relinquish dominion and control over the trust property, he may utilize an independent trustee who may exercise the powers prohibited to the grantor.<sup>13</sup> Thus, *eg*, the grantor could utilize his lawyer and bank as co-trustees, thereby meeting the independent trustee requirement, and the lawyer could be relied upon to follow reasonable and lawful instructions from the grantor. (However, if the transfer to the trust is to be made without a gift tax, the trustee must be required to distribute all income. The power to withhold income is a power that cannot be given to *even* an independent trustee if the transfer is to be tax-free.)

One of the problems with the short-term trust requirement to currently distribute all income is the distribution of such income to a minor where the income is supposed to be conserved to provide for his college education. This problem is easily solved. Again, the answer is predicated upon the parents' ability to influence the child. To the extent this ability is present, as it usually is in respect to monetary matters, the parents can simply insist that the child deposit the



trust distributions in a savings account, or any of the other vehicles for conserving capital.

#### DISPOSITION

Disposition mode, as with other facets of this transaction, is a function of the grantor's overall financial planning objectives and, to some extent, the type of trust utilized. As I indicated, with the minor's trust, the trust property must pass to the minor upon his attaining age 21. However, although the property must pass to the child, he could make a gift of the property back to his parents (if they have need of the income therefrom) after his education has been completed. With the short-term trust, the grantor can have the property revert to him any time after the trust has been in existence for more than ten years.<sup>14</sup>

Once the child's education has been provided for, the grantor must decide what he wants to do with the income producing property. Thus, *eg*, if the physician's income is, at that time, high, and if he has his retirement well provided for, he may wish to simply leave the property with the child to whom it has already been transferred. This approach is especially desirable because the property will not be included in the physician's gross estate for estate tax purposes. (Good tax planning dictates that, whenever possible, assets should be transferred prior to death, thereby taking advantage of tax-free gifts and, in the event gift taxes are incurred, the fact that gift tax rates are considerably lower than estate tax rates.)

However, after the child's education has been provided for, the physician may find himself approaching retirement age, or may wish to take an early retirement, but may find himself lacking the income necessary to maintain his standard of living without the income from his professional practice. Under these circumstances, the physician may be in need of the income from the income producing property. Rather than re-acquire the property, which would cause it to be included in his estate for estate tax purposes, the physician could have the child make a gift of the income back to his parents. To the extent that both parents are living at such time, the child could make tax-free gifts of \$6,000/year to his parents.

Admittedly, this approach creates an intrinsic psychological weakness, whereunder the family patriarch may feel his identity threatened by accepting gifts from his children,

the complete antithesis of the patriarch's role. However, one must realize that we are attempting to effect tax savings, and that such tax savings are difficult to obtain without the ability to adjust income between family members.

Despite the preceding, in most cases the physician will have sufficiently provided for retirement income and it will be unnecessary for him to re-acquire the income producing property. Thus, the child to whom he has transferred the property will have a source of income (and a mortgagable interest) with which to meet his own financial needs at a time when such needs are great.

#### CONCLUSION

Though the plan herein discussed is relatively simple, there is a maximum amount of flexibility with which to meet many planning goals. The utilization of a maintenance and leasing contract with a reputable builder will absolve the physician of management responsibilities on the investment. Moreover, the property will be well maintained and, if suitably located, will hold its value and, more likely than not, will appreciate. Thus, this low-cost investment vehicle, if properly structured, may be utilized in conjunction with each of the physician's children and will fulfill long-term tax and estate planning objectives. □

#### NOTES

1. Gaddis, *A Real Estate Transaction for the Physician and His Children*, 66 OSMA JOURNAL 488 (1973) Hereafter cited as GADDIS.

2. IRC 167(j). Moreover, new residential property is highly favored under the Code, as compared to used residential rental property. Thus, although accelerated depreciation is allowed in respect to used residential rental property, the amount of this depreciation allowance is only 125% of the straight line amount. IRC 167(j)(5). Whereas, new residential rental property may be depreciated at a rate not to exceed 200% of the straight line rate. IRC 167(j)(2). Obviously, from a tax-shelter point of view, new residential rental property is more desirable.

3. GADDIS, 490, Table IV.

4. GADDIS, 491, Table V. The investment amounted to \$5,000.00, with the balance of the project financed at 7.5% for 25 years.

5. IRC 152. Even this deduction may be lost if you are responsible for less than 50% of the child's support, which may well be the case, despite the \$5,000.00 contribution, where your child is married and/or undertaking costly post-graduate education.

6. IRC 2503(c). The primary benefit of which is the availability of the \$3,000.00/donee/year annual exclusion for gift taxes on transfers to such trusts.

7. IRC 2503(c). Sets forth the requirements which must be met before donor will be allowed to avail himself of the \$3,000.00/donee annual exclusion for gift transfers. These requirements are sometimes spoken of as the requirements for a "minor's trust," and are as follows: 1) The corpus and the income therefrom may be expended for the benefit of the minor before he becomes 21, and 2) where not so expended, a) they pass to the minor on his reaching 21, or b) if he dies before then, they are payable to his estate or as he may appoint under a general power of appointment.

8. Regs. 25.2503-4(c).

9. IRC 676. 10. IRC 673(a).

11. IRC 674.

12. IRC 677.

13. *Skemp v. Comm.*, 168 F. 2d 598 (1948).

14. IRC 2037(b). If the grantor retains this so-called "reversionary" interest in a short-term trust, the value of the property held in trust will be included in his estate for estate tax purposes.

1210 Mid-Continent Building, Tulsa, Oklahoma 74103





# News From The Oklahoma State Department of Health

## INFLUENZA VACCINE RECOMMENDATIONS\*

### INTRODUCTION

The effectiveness of the inactivated influenza vaccines is variable and their protection relatively brief. However, they should be given to the chronically ill and the elderly.

### BIVALENT VACCINE

Bivalent influenza vaccine this year will contain a new type A influenza virus representative of currently prevalent "England" strains. Each adult dose will contain not less than 1200 CC A units of antigen: 700 CC A units of a type A strain comparable to the prototype, A/Port Chalmers/1/73 (H 3 N 2) and 500 CC A units of a type B strain, B/Hong Kong/5/72. Vaccines from all producers are highly purified and should be

relatively free of significant adverse reactions.

### GENERAL RECOMMENDATIONS

Annual vaccination is recommended for the elderly and persons who have such chronic conditions as: (1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; (2) chronic bronchopulmonary diseases; (3) chronic renal diseases; and (4) diabetes mellitus and other chronic metabolic disorders.

### SCHEDULE

Primary or booster vaccination consists of a single dose of vaccine (dose volume and administration route are specified in the manufacturer's labeling).

### PRECAUTIONS

Influenza vaccine should *not* be administered to persons clearly hypersensitive to egg protein, ingested or injected. ☐

\*Reference: Public Health Service Advisory Committee on Immunization Practices.

## COMMUNICABLE DISEASES IN OKLAHOMA FOR JUNE, 1974

DISEASE	June 1974	June 1973	May 1974	Total To Date 1974	1973
Amebiasis	3	1	1	10	14
Brucellosis	2	—	—	4	2
Chickenpox	94	125	167	789	1267
Encephalitis, Infectious	16	19	2	31	27
Gonorrhea (Use Form ODH-228)	907	803	1019	5217	5304
Hepatitis, A, B, Unspecified	78	132	98	565	597
Leptospirosis	1	—	—	1	—
Malaria	—	—	—	1	1
Meningococcal Infections	1	5	—	12	15
Meningitis, Aseptic	7	6	6	27	25
Mumps	42	76	52	350	372
Rabies in Animals	22	28	14	86	125
Rheumatic Fever	—	—	4	7	9
Rocky Mountain Spotted Fever	18	28	7	28	45
Rubella	4	8	6	33	167
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	4	9	6	23	49
Salmonellosis	12	16	45	119	91
Shigellosis	19	22	15	75	110
Syphilis, Infectious (Use Form ODH-228)	4	11	13	74	96
Tetanus	—	2	—	—	3
Tuberculosis, New active	35	26	24	153	154
Tularemia	3	6	1	6	13
Typhoid Fever	—	1	—	—	2
Whooping Cough	2	—	1	8	14



## Medical School Information Campaign Launched

Oklahoma physicians, via the Oklahoma State Medical Association, have pledged up to \$20,000 to finance an information campaign to aid the beleaguered University of Oklahoma Health Sciences Center. The action was taken when the OSMA's Board of Trustees met on Sunday, July 14th.

Actions of the trustees grew out of concern about the financial condition of the OU Health Sciences Center and recent staff resignations, notably that of Robert M. Bird, MD, Dean of the School of Medicine.

Trustees pledged \$5,000 out of the association's operating budget, and launched a campaign to raise an additional \$15,000 by voluntary contributions from the membership. During the first two days of the campaign, Oklahoma physicians responded with nearly \$3,000 in contributions.

After the trustees session, John A. McIntyre, MD, Chairman of the Board said, "Oklahoma physicians are gravely concerned that confusion about necessary funding for the University of Oklahoma Health Sciences Center will affect the quality and availability of educational programs which are vital for the production of adequate health manpower for our state today and in the future." C. S. Lewis, MD, Tulsa, will head the association's information campaign. He is serving as Chairman of the OSMA's Medical Center Liaison committee.

In announcing the campaign Jack L. Richardson, MD, OSMA President, said, "Our efforts will be constructive. We will support the medical center. We will supplement those efforts that are already in progress and will add another dimension — that of the private practicing physician."

The medical president went on to state, "The OSMA is not directing criticism toward any of the parties or individuals officially involved in the current controversy. The Board of Trustees is appealing to the responsible parties . . . those in positions of management and those with financial responsibility . . . to quickly take whatever steps are necessary to assure the

uninterrupted continuity of essential services and training programs now under way for the benefit of our citizens."

Information campaign itself will be directed toward legislators, community leaders, and the medical profession.

In a letter to all association members President Richardson said, "The program we will launch will require your participation . . . we will bring factual information to you through a series of regional meetings throughout the state . . . and the success of our efforts will depend on the state physicians exercising their political influence by contacting legislators and other leaders in the jurisdictions. You hold the key which will unlock solutions to the financial and management problems which have plagued the OU Health Sciences Center throughout its history . . . the OSMA can plan and coordinate a program, but we can only be successful if our 2,500 individual members put punch into the program at the grass roots level."

The information program itself is being put together by a Tulsa based advertising executive, Mr. Chuck Schnake.

Preliminary meetings with the leadership at the Health Sciences Center were conducted immediately after the Board of Trustees' action. Doctor Lewis and Mr. Schnake met with the Dean of the Medical School, Head of the University Hospital, and various department chiefs the following week. □

## Everett To Chair Faculty Board

Mark A. Everett, MD, has been appointed to succeed John A. Schilling, MD, as chairman of the faculty board for the OU College of Medicine.

The resignation and departure of Doctor Schilling from the faculty necessitated the naming of a new chairman for the faculty board. Doctor Everett will serve as chairman of the board for the remainder of the 1974-75 academic year, and for all of the 1975-76 year. □



## OSMA Board of Trustees To Seek PSRO Grant

A PSRO Planning Grant request will be made by the OSMA to HEW. The association's Board of Trustees reluctantly voted on Sunday, July 14th, to begin implementation of the controversial "Professional Standards Review Organization" law.

John A. McIntyre, MD, Enid, Chairman of the OSMA board, announced the decision and stated, "we will enter the planning phase of this so-called PSRO Program with skepticism and we will withdraw from participation at any time when we consider that federal intervention in the area of medical care is compromising our ability to serve our patients."

The PSRO law, which became effective January 1st, requires medical foundations to monitor health services given to aged and needy persons who qualify for the federal Medicare and Medicaid programs.

"It will be a computerized system," McIntyre explained, "where some 200,000 claims for health services to these citizens will be checked against criteria to determine if the expense is justified and if the services are of acceptable quality. Services felt to be unnecessary according to the terms of the law will be denied for payment."

Under PSRO claims will be screened against criteria in order to assess: (1) the medical necessity of the care; (2) the quality of the care rendered; (3) and the appropriateness of the situs of care. This would be done primarily at the institutional level by comparing admissions data and services rendered against norms or standards of care which are in use by the PSRO. Cases which fall outside the norms, and which cannot be resolved at the hospital level, will be referred to physician review teams for settlement.

Under the PSRO law, no Medicare or Medicaid claim may be paid which is not approved by the PSRO.

The law itself became effective January 1st of this year. Under its terms, until January 1st, 1976, physician organizations have the option of assuming control of the program to monitor all appropriate cases involving institutional care. After that date, if the profession has not exercised its option, the secretary of HEW may assign the program to any public agency or non-profit organization.

Doctor McIntyre said, "Faced with this situation as prescribed in a federal law, we see no alternative but to get involved, because we feel that practicing physicians are best qualified to assess the adequacy and appropriateness of medical services." However, the medical leader warned the government that cooperation from state physicians will end abruptly if it is determined that federal regulations result in a deterioration of the quality of health services, or if the confidentiality of the physician-patient relationship is violated by computer technology or by the federal bureaucracy."

"While we favor professionally-directed peer review and have a good record of voluntarily carrying out such programs throughout our professional history," McIntyre said, "The government will have to demonstrate to us that this particular program can be operated for the good of the public. We will not tolerate unfair treatment of our patients or ourselves, and the lid will really blow off the first time we read that someone's personal health history is used for entertainment at a Washington cocktail party."

The OSMA has been in the forefront of opposing PSRO since its inception. As early as 1969, OSMA representatives went to Washington to oppose this form of peer review. Association officers and delegates to the AMA have consistently sought to repeal the law, to develop alternatives, and to influence national medical policy against this particular measure.

In seeking repeal, the association did recognize that such efforts might fail, and it created the Oklahoma Foundation for Peer Review as a vehicle to study the implementation of the program and perhaps qualify as an operational PSRO if necessary.

While the OSMA pursued its repeal efforts, the foundation proceeded to develop a basic operational concept which would comply with the law in the least disruptive manner.

Repeal efforts by the OSMA were not without some result. Almost all members of the Oklahoma Congressional Delegation committed themselves to repeal, but other states could not produce similar results.

Applications for PSRO planning for operational funds have been received in Washington from professional groups in 46 states. In June the AMA House of Delegates once again failed to support a national repeal effort by a vote of 184 to 57. While there are probably few medical associations that favor PSRO, the majority are simply resigned to their belief that nothing can



be done to repeal the law.

In view of the national trend, the OSMA Board of Trustees exercised the authority granted to it by the House of Delegates of the association to instruct the Oklahoma Foundation for Peer Review to seek federal planning funds for the purpose of perfecting a PSRO operational concept for Oklahoma. The planning grant to be sought will probably amount to \$75,000 or more.

OSMA President Jack L. Richardson, MD, is hopeful that all state physicians will understand the position of the association at this time. "We were among the first to resist this law, we have been steadfast in our efforts to muster a solid national program to repeal it, and we are now among the last states to apply for any sort of participation. There simply does not seem to be any other alternative open to us at this time."

"We will still have another decision to make after the planning period is over," the president added. "If we should decide in the end to begin PSRO operations, we will make it clear to all concerned that we will act in good faith and will expect the government to do so . . . if the program serves no public good, or if it is deleterious to our patients' interest or to ours, I assure the membership that we will be among the first to back out of this operation."

This same thought was reiterated by OSMA Board Chairman John A. McIntyre, MD, when he said that the profession "will enter the planning phase in good faith and will be hopeful that something good can result from such a partnership effort." He went on to point out that operational costs for the PSRO program will be high. "Here in Oklahoma . . . tax payers' cost to operate the program will eventually be \$2,000,000 or more a year, and nationally the law could cost more than \$200,000,000 annually," he said. □

## **American Medical Directory Available From AMA**

The 26th Edition of the "American Medical Directory" is now available from the American Medical Association. The four-volume, hard cover, directory provides biographical information on every physician in the United States and on all foreign physicians temporarily residing in the U.S.

There are over 371,000 biographical entries in the 1974 Edition, which is 27,000 new entries

since the 1969 edition.

All inquiries on ordering the 1974 directory should be directed to the Order Handling Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

The four-volume directory costs \$125 when ordered by persons in the United States, US Possessions, Canada or Mexico. The price for orders outside the area is \$15 more. □

## **Self-Assessment Catalog Published By AMA**

A list of self-assessment programs for medical doctors has been published by the AMA's Department of Continuing Medical Education. The "Directory of Self-Assessment Programs for Physicians," second edition, lists self-assessment programs sponsored by all major specialty societies.

The directory is available from the AMA for \$1.00 per copy. Orders should be directed to the AMA's order department, 535 North Dearborn, Chicago, Illinois, 60610. A check in the appropriate amount should be sent with the order.

Each directory lists programs available on 21 topics including new programs on allergy, cardiology, chest disease, colorectal and anorectal surgery, and emergency medicine.

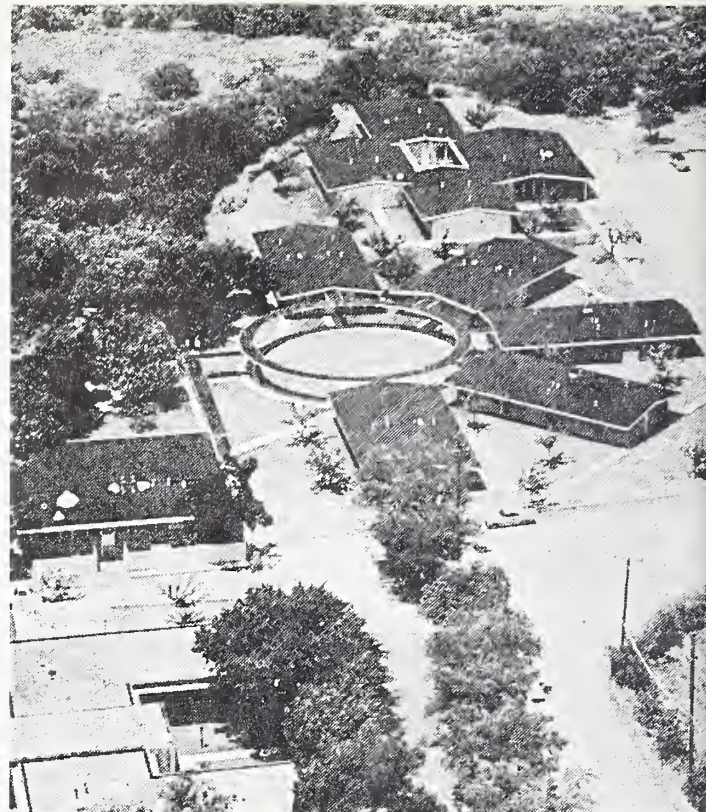
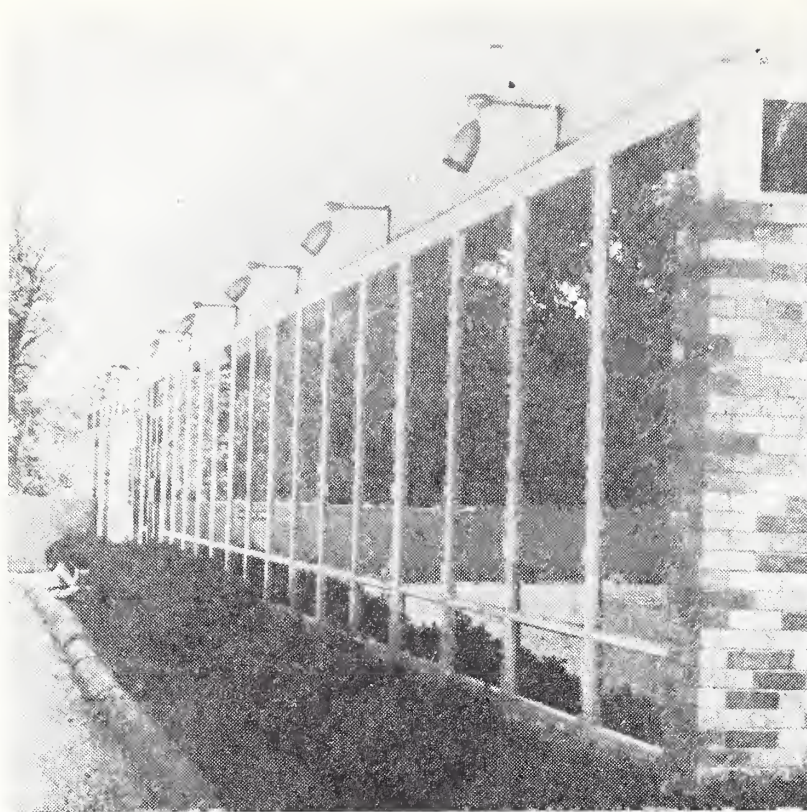
Each program is listed by topic and sponsor, and is described in the directory with regard to an intended participation, sites and times of tests, objectives and content, format, time required, method of scoring, age to learning provided, fees charged and whom to write for further information. Dates of the first tests and most recent revisions are also supplied.

The forward to the new directory states, "there never are passing or failing grades (in these courses). When a program provides 'norms' for comparison with peers, these are usually based upon the scores of those who took the test 'closed-book' before a deadline set early in the program.

"All tests are voluntary and designed to preserve the anonymity of individual participants, except that in some instances residents' scores are provided to their program directors."

The directory does not list programs sponsored by the American Medical Association. Activities of the association are confined to further research and development in educational programs, and to the educational programs offered at the AMA's mid-winter and annual meetings each summer. □





## **BEVERLY HILLS HOSPITAL BEVERLY HILLS CLINIC**

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## Physician Placement Service Available

A physicians placement service, set up solely to assist state communities in attracting doctors, has announced its first successful placement with a general surgeon accepting a position in Prague, Oklahoma.

An agency funded in part by the University of Oklahoma, the Oklahoma State Medical Association and the OU Health Sciences Center, the Oklahoma Council for Health Careers, has announced that Sabry Ali Radwi, MD, currently a surgical resident with Veterans Administration Hospital in California, will set up practice in Prague in June.

Placement of this first physician was the end result of three surveys used in helping communities solve their physician shortage problems. The placement service, originally organized by the Oklahoma State Medical Association under the direction of Don Blair, took form early this year in response to the increasingly vocalized need in rural communities for assistance in obtaining physicians. Executive Director of the program is Ken Hager. The council, formed in 1971 and funded by several state medical agencies including the OSMA, first noted the need for physician placement when council officials were touring the state trying to place persons in allied health and paramedical positions. Operating under the Oklahoma Regional Medical Program, the council conducted its annual health job fairs in 1972 and 1973. These led to an increased awareness of the need to create a clearing house to put physicians in those communities where they could do the most good.

Work on the three surveys began in an attempt to determine where the doctors are needed and what they are looking for in the community. One survey is filled out by the physician, another by community leaders who have sought assistance in placement and another by the townspeople themselves.

One of the first evaluations made by the council is to determine whether or not the community that is looking for a physician can actually support another one.

Thus far, city officials from 65 communities in Oklahoma have filled out the Physicians Placement Survey and 214 applications have been received from either physicians or medical students interested in placement. □

## Acapulco OSMA Tour Leaving In January



The Las Brisas Hotel in Acapulco, one of the most luxurious in all of Mexico is spread over the side of a mountain overlooking beautiful Acapulco Bay. The hotel is made up of numerous small houses, called casitas, each with its own private pool, that may be shared by two couples. The OSMA tour to the Las Brisas will leave Oklahoma City on January 15th and return on the 21st. Persons interested should contact the OSMA before September 1st.

The OSMA sponsored tour to Acapulco, Mexico, is filling rapidly. The tour will leave Oklahoma City January 15th.

In Acapulco persons on the tour will stay at the luxurious Hotel Las Brisas for six days and seven nights. Each couple will have its own casita and will share a private swimming pool with one other couple.

Transportation to and from Acapulco is by economy class jet leaving on January 15th and returning on the 21st.

A continental breakfast is delivered to the room each morning consisting of hot coffee, sweet rolls and fresh seasonal fruit.

The Las Brisas has an interesting rule: No tipping.

The Las Brisas is one of Mexico's finest luxury hotels. Five tennis courts are available. Hospitality and entertainment is offered in the Arsonal Pub or the Dungeon. The Las Brisas pink and white candy-striped jeeps for rent to hotel guests are well known throughout Acapulco.

Persons interested in going on the Acapulco Tour should contact Mr. Don Blair c/o The OSMA, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118. Deadline for reservations is September 1st. □



## DOCTOR, WHAT WILL YOU EARN?

It depends, of course, on your age and annual earnings, but the amount can quite reasonably exceed \$400,000.

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## Forty Six Preceptors Named For OU Med School

A special preceptorship program has been announced for the 1974-75 academic year. Forty-six physicians practicing in small Oklahoma communities will work with fourth-year medical students from the University of Oklahoma College of Medicine.

The program, separate from the original preceptor program established by the college of medicine in 1949, is in its second year. In addition to the five-week preceptorship all senior medical students are required to serve, students in this special program may elect to receive additional community practice experience ranging from five to fifteen weeks. During this time they are paid a small stipend to partially cover living expenses.

Director for the preceptorship program is Thomas Lynn, MD, professor and chairman of the Department of Family Practice and Community Health.

Preceptor physicians have faculty appointments and are chosen on the basis of ability and interest in the program. Preceptors include family practitioners, pediatricians, and specialists in internal medicine.

Physicians recently named as preceptors in the special program are: George K. Stephens, pediatrics, Ada; Malcolm Mollison, family practice, Altus; Alfred Hinkle, general practice, Alva; Frederick D. Mannerberg, internal medicine, and David D. Rose, internal medicine, Ardmore; James Young, internal medicine, Bartlesville; Ed L. Calhoon, general practice, Beaver; William F. Hudson, general practice and Joe T. Bledsoe, internal medicine, Buffalo; William Harrison, internal medicine, Robert E. Herndon, pediatrics, James W. McDoniel, family practice, and Ronald E. Orr, pediatrics, all of Chickasha.

Also, Orville U. Holt, general practice, Claremore; E. H. Lindley, general practice, Duncan; Bob L. Bruton, general practice, Durant; William M. Featherston, pediatrics, Elk City; F. W. Hollingsworth, family practice, El Reno; William H. Simon, pediatrics, and William R. Smith, internal medicine, both of Enid; Robert E. Ringrose, internal medicine, Guthrie; Elvin L. Buford, general practice, Guymon, and J. William Finch, internal medicine, Hobart.

Others are Royce C. McDougal, general practice, Holdenville; Kenneth L. Evan, general practice, Kingfisher; Robert H. Drewry, inter-

nal medicine, Lawton; Charles K. Holland, internal medicine, and Thurman Shuller, pediatrics, both of McAlester; Glenn W. Cosby, family practice, Miami; Maurice C. Gephardt, internal medicine, Muskogee; Claude H. Williams, general practice, Okeene; Noel E. Miller, general practice, Okemah, and John H. Lindsey, general practice, Pauls Valley.

Also, Richard L. Winters, family practice, Poteau; John G. Rollins, general practice, Purcell; Orville H. Patterson, general practice, Sapulpa; Kenneth E. Whinery, general practice, Sayre; Walter H. Dersch, Jr., internal medicine, Shattuck; Jake Jones, Jr., pediatrics, Shawnee; Perry Klaassen, general practice, Spencer; G. Edward Shissler, pediatrics, and Tim K. Smalley, internal medicine, both of Stillwater; Burdge F. Green, general practice, Stilwell; Richard A. Conley, family practice, Watonga; Lloyd G. William, general practice, Wetumka, and Murlin K. Braly, general practice, Woodward. □

## AMA Delegates Actions Summarized

Delegates to the American Medical Association's House of Delegates met for a total of 19 hours and 38 minutes June 23rd through the 27th at the 123rd Annual Convention of the American Medical Association in Chicago. The house acted on 66 reports and 137 resolutions for a total of 203 items of business.

The following is a brief summary of the major actions taken by the House of Delegates.

PSRO: Following lengthy debate before the reference committee the House of Delegates adopted a resolution that instructed the Board of Trustees to seek constructive amendments to the PSRO law, particularly and potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care, and the authority of the secretary of HEW.

The AMA was also directed to continue its efforts to achieve legislation which would allow the profession to perform peer review according to established medical philosophy and in the best interest of the patient. The resolution points out that any state association which elects "noncompliance" with PSRO is not prevented from doing so by this new policy of the AMA. However, the resolution did urge any associations using noncompliance to develop effective non-PSRO review programs as constructive alternates.



**National health insurance:** Two statements on NHI were adopted after lengthy debate. One calls for the AMA's Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance committees which will insure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable congressional and public support for their adoption."

**Drug Industry:** One resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA contend have tended to stifle the development and marketing of new drugs in the United States.

**Medicine and Government:** Several resolutions effecting physicians and the government, and other third parties, were considered and adopted by the delegates. One directs the AMA to seek an extension of from 30 to 90 days to respond to proposed health regulations printed in the federal register, and that government agencies using the federal register for rule-promoting purposes be urged to hold public hearings on the merits of proposed legislation.

The association has been directed to oppose the concept of claims rejection on the basis of "diagnostic admission" or "lack of medical necessity" without prior physician notification, and to recommend a peer review mechanism be established independent of the third party carrier to review claim conflicts.

The AMA's new uniform health insurance claim form is to be promoted by the association to all third parties to accept its usage. State medical associations are encouraged to seek acceptance of the form by various state insurance commissioners.

**Confidential records:** The house adopted two reports baring on confidentiality of medical records. Report I of the Council on Medical Service describes a wide ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information."

Report II of the AMA's Board of Trustees notes that the Council on Legislation is developing model laws as a guide to possible state legislation to preserve confidentiality, and that a

model bill should be ready for consideration by the delegates when they meet again this fall.

**Antisubstitution Laws:** Delegates instructed the staff of the AMA to continue to inform the public and the profession of the potential problems and risks in permitting the non-physician substitution of drugs of choice prescribed by physicians. State associations were urged to support this position whenever a state legislature considers changing these antisubstitution laws.

**Allied Health Occupations:** A moratorium on the licensure of allied health occupations until the end of 1975 was called for by the delegates. This would give the AMA, and other interested organizations, time to study the proliferation of licensed allied health groups.

**Hospitals and Government:** The delegates reaffirmed the AMA's opposition to blanket pre-admission certification of hospital patients by governmental or hospital edict. □

## Oklahoman Chosen President of PA Academy

Newly named President-Elect of the American Academy of Physicians Assistants is Thomas R. Godkins, Associate Director of the University of Oklahoma Health Sciences Centers' Physicians Associate Program.

Godkins will assume the presidency of the PA organization during its next annual meeting in April, 1975. He has served previously as president in 1972-73.

The academy, largest national organization representing Physicians Assistants, sponsors and participants in the American Medical Association's accreditation process as a member of the Joint Review Committee. It also is responsible to the Council on Medical Education of the AMA and is a participating organization of the National Commission for Certification of Physicians Assistants, recently established by the AMA, the academy and other interested groups.

Godkins is a native of Pittsburgh, Pennsylvania, and a graduate of Youngstown, Ohio, University and the Duke University Medical Centers Physicians Assistants Program.

He worked as a physicians assistant at the Mayo Clinic-Mayo Foundation, Rochester, Minnesota, before joining the Oklahoma Health Sciences Center faculty as associate director of the program. □



## **New Alcohol Treatment Center Opens in OKC**

A new alcoholism treatment center has been opened in the Oklahoma City area. Under the auspices of the State Department of Mental Health, the new center is a part of the central Oklahoma alcohol treatment program. It is located at 4444 North Classen Boulevard in Oklahoma City.

Professional personnel at the northwest center include a psychiatrist, psychologist, and a staff of social workers. The center is one of three available in the Oklahoma City area. The other two are located at 1501 Northeast 11th and at 707 Northwest 8th Streets.

The new center offers individual, group and family therapy for alcohol-related problems, as well as social services and followup as an integral part of the treatment.

Treatment at the alcoholism center is on the outpatient basis only. Fees for services are on a sliding scale based on the individual's ability to pay. No one, however, will be refused services on a financial basis.

The total program at the alcohol treatment center consists of emergency detoxification, in-

patient, outpatient, intermediate care, consultation, education, and social services both in Oklahoma and Cleveland counties. □

## **Medical Doctor Shortage To End in 1980**

The shortage of physicians in the United States will be over by 1980 according to a recent article in *The Journal of the American Medical Association*.

According to James K. Cooper, MD, and Karen Heald, with the Rand Corporation, Washington, DC, there probably is no shortage today in terms of overall numbers. Rather, there are not enough physicians in the primary treatment areas, and there is maldistribution of doctors across the nation.

The frequently quoted "shortage of 50,000 doctors" is probably an exaggerated figure, the report declares. The total number of physicians has more than kept up with the growth of population. In 1950, the total number of active non-federal physicians per 100,000 population was 119. According to the article, in 1971, the ratio had increased to 152.

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The article appeared in the March issue of JAMA, the national magazine that is distributed to all American physicians. Many more physicians today are specialists than in past years, according to the article.

Although the total number of physicians and the physician to population ratio in this country are greater now than ever before, the ratio of primary care providers has decreased, and there is considerable disparity in the number of physicians in different geographic areas.

It is estimated that by 1980 there will be a total need for between 413,000 and 436,000 physicians. Several factors are operating to meet this high level of need. Medical schools are expanding faculties and excelling in medical education. Medical schools will be producing 17,000 new doctors a year in 1980.

The report ended with a comment that the so-called doctors shortage will be over by 1980 and that now is the time to direct efforts at the real problems . . . physician maldistribution and a relative shortage of primary care physicians. □

## New Program For Veterans

A new program for veterans, to be known as CHAMPVA, has been announced by the director of the Denver office for the Civilian Health and Medical Programs for the Uniform Services.

Legislation enacted in 1973, the Veterans Health Care Extension Act, authorizes the new program and provides benefits for the spouse or child of a veteran who has a total, permanent service connected disability, or the surviving spouse or child of the veteran who dies from a service connected disability.

It is estimated that there are approximately 150,000 beneficiaries of the new program nationwide. The determination for eligibility under the CHAMPVA program is the responsibility of the Veterans Administration. Prospective beneficiaries will make application to the nearest VA hospital or clinic for their ID card. Once eligibility has been determined and an appropriate VA identification number issued, CHAMPVA beneficiaries will have complete freedom of choice in selecting their civilian health care providers.

An interim letter of authorization will be issued to designate CHAMPVA beneficiaries prior to issuance of the permanent ID cards. These letters, and the ID cards of the latter, are the authority for physicians to deliver authorized services to these beneficiaries and to mail claims for their services through the CHAMPUS Program. The CHAMPUS claim form, number 1863-2, may be used for CHAMPVA claims. Claims from Oklahoma physicians should be submitted to Oklahoma Blue Cross and Blue Shield, P.O. Box 3238, Tulsa, Oklahoma, 74102.

CHAMPVA benefits are the same as for dependents of retired and deceased uniformed personnel under CHAMPUS. Questions regarding CHAMPVA may be referred to the CHAMPUS office in care of Oklahoma Blue Cross and Blue Shield in either Oklahoma City or Tulsa. □

## DEATHS

EMRY HYATT, MD  
1892-1974

A long-time Tulsa internist, Emry Hyatt, MD, died at his home in Florida, June 22nd, 1974. A co-founder of Tulsa's Springer Clinic, Doctor Hyatt had retired in 1962. He was graduated from the University of Illinois College of Medicine in 1920 and established his practice in Tulsa in 1924.

Doctor Hyatt held a Life Membership in the OSMA and had been described as a distinguished physician, a genial friend and a dedicated administrator to his fellow man.

HARLAN K. SOWELL, MD  
1917-1974

An Oklahoma City anesthesiologist, Harlan K. Sowell, MD, 57, died June 26th, 1974. A native of Lubbock, Texas, Doctor Sowell had lived in Oklahoma City most of his life. He was graduated from the University of Oklahoma College of Medicine in 1943, where he later became an Instructor in Anesthesiology. He had served with the US Navy during World War II. □



## BOOK REVIEWS

**The Cardiac Arrhythmias.** By Brendan Phibbs, MD, Associate Professor of Medicine, University of Arizona College of Medicine, University Hospital, Tucson, Arizona. Second edition. 197 pp., 264 illustrations. St. Louis: The C. B. Mosby Company, 1973. \$7.50.

In writing this book "The Cardiac Arrhythmias" Doctor Phibbs has sifted through a tremendous amount of rather complex and often controversial information and managed to effectively reduce it to a practical and usable form. A form which I think is comprehensible by all who read it. The text is directed concisely toward the care of the patient without frills or minutiae. The author attacks the problem at hand, deleting the extensive and more recondite aspects of this subject. As he states in the preface of this text, this is a basic book for the non-cardiologist. Stress is placed upon accurate diagnosis of arrhythmias by means available to anyone who cares for cardiac patients. Major emphasis of course is placed upon EKG interpretation. Clinical diagnosis is also discussed and its limited value in this particular aspect of cardiac care frequently pointed out. Those more sophisticated parameters of cardiac diagnosis, such as bundle of his recordings are placed in their proper perspective. They are, granted, of great research and theoretical importance but do not frequently yield practical clinical information. They are therefore mentioned only briefly in this book.

The book is divided into four sections or "parts" beginning with basic facts of anatomy and physiology of the conduction tissues of the heart. Also included in this section are some basics of electrocardiography.

Part two deals with "simple" arrhythmias and includes variations of sinus beats, tachyarrhythmias, AV and intraventricular blocks and atrial fibrillations and flutter. It is particularly clear and well illustrated.

The third part of the book is entitled "complex" arrhythmias. Digitalis-induced abnormalities, combinations of abnormal rhythms and fatal arrhythmias are presented. Terms such as interference, disassociation, and confusion are introduced and simplified to a workable and usable form.

The final section discusses briefly treatment, cardiac pacing and cardioversion. Each section has one or more chapters entitled "Problems,

Practice and Re-inforcement." These are excellent, demonstrating the various arrhythmias with a brief case history, diagnosis, discussion and appropriate treatment. Throughout the entire text the author has interjected his own practical experience and cautions in the diagnosis and treatment of arrhythmias. His basic fundamental and straightforward approach to treatment is well accepted and the stress on patient care I think will be appreciated.

Criticisms I think are minor and few. There will not, of course, be total agreement on the book's interpretation of certain arrhythmias nor their mechanism and treatment. More emphasis and time could be given to the subject of cardiac pacing, cardioversion and defibrillators. Although very enlightening, this section of the book is quite brief and yet one that is constantly assuming more and more importance in the care of cardiac patients.

In summation, I think the best way to characterize this brief and easily read text is with the word "practical." It can be highly recommended for students, house staff and the non-cardiologist involved in the care of cardiac patients. The complexities of cardiac arrhythmias are simplified to a more or less usable form by an author with extensive clinical experience in the field. *Jerry Razook, MD* □

**A TIME FOR REMEMBERING.** By Joseph Garland, 203 pp. New England Journal of Medicine, Boston, 1972. \$6.50.

This is the autobiography of Doctor Joseph Garland who served as editor of the *New England Journal of Medicine* from 1947 to 1967. Most readers are not aware that Doctor Garland was a well-regarded pediatrician, hardly known outside the Boston area. His second career, that as an editor, brought him the most notice. Under his editorship, the *New England Journal of Medicine* flourished.

The story describes his ancestors, his parents, his course through medical school, his life and associates as a pediatrician, and his travels. He started his journalistic career in his teens as a part-time editor of the high school yearbook.

Despite the many interesting points, Doctor Garland does not truly give us insight into how he managed the journal and gave it the flavor which he did. Despite this, those who are interested in medical journalism will enjoy this book. *Harris D. Riley, Jr., MD* □



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## FROM THE TRENCH TO THE BENCH - CLINICAL LABORATORY ASPECTS OF ANAEROBIC INFECTIONS

THE UNIVERSITY OF TEXAS HEALTH  
SCIENCE CENTER AT HOUSTON

Division of Continuing Education

and

Medical School

BAYLOR COLLEGE OF MEDICINE

THE UNIVERSITY OF TEXAS  
SYSTEM CANCER CENTER  
M. D. ANDERSON HOSPITAL AND  
TUMOR INSTITUTE AT HOUSTON

and

HOUSTON ASSOCIATION OF MEDICAL  
MICROBIOLOGISTS

October 17th, 1974  
Houston, Texas

# Rondomycin<sup>®</sup> (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.) Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE:** **Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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## *The Passing Of Time*

For most patients, good medical care is that which is immediately available, rendered with compassion, held in confidence and subject to no compromises. It must effect the relief of pain, the alleviation of anxiety, the maximal preservation of faculties and a tenable prognosis. To the patient and his loved ones, good medical care means manifest concern, expressed in a personal, unhurried manner by cordial, qualified, unmercenary professionals.

Good medical care demands the expenditure of time and cannot be rendered briefly. No physician can render good medical care unless he spends the time required to satisfy his patients' needs. In order to insure that they are satisfied, he must first take the time to identify them. Very often, this is a more difficult and time-consuming task than the satisfaction of those needs.

There is simply no short route to good medical care. Time is its most indispensable ingredient. Although it does not hold that the greatest expenditure of time achieves the highest quality of care, good care and brevity are mutually exclusive terms.

One of the surest ways to invite disaster in the practice of medicine is to act in haste. The most certain way to alienate a patient is to be abrupt, hurried or casual with him. The most prestigious reputation, the most experienced skill, the most unanimous acclaim cannot compensate the sin of brevity in a patient's

evaluation of the quality of medical care he received from the hands of a technician who didn't take the time to be a physician. Compassion cannot be expressed in haste. Anxiety cannot be relieved in a moment. Sincerity, concern and personal respect can be demonstrated only through the devotion of time.

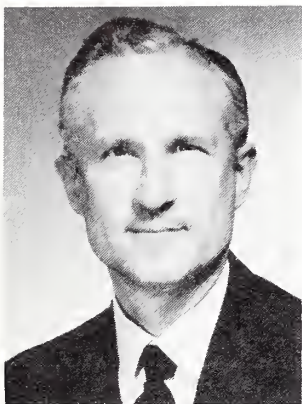
Tragically, time appears to be the least compensable aspect of medical care. Most third-party payment plans pay for labels rather than care. Whether a routine office visit requires six or sixty minutes is immaterial to the payer. An office visit is an office visit, an appendectomy is an appendectomy and a case of pneumonia is a case of pneumonia.

Further evidence of the disregard for the value of time is our critics' insistence that we become more "efficient" in our "health care delivery patterns." What they really mean is that we must see more patients in even less time than we now require.

Now, we are awaiting the announcement of "norms and standards of care" which are being developed by our specialty groups and boards. When they are determined, it is almost a certainty that labels will be more precious than time. We will be compensated for treating a condition, not for providing care. And the quality of that care will be appraised by those individuals least capable of it. The patient, the physician and the hallmark of quality, time, will be thoroughly ignored.

We will all become merchants. *MRJ*





Just when one is about to despair of the entire political situation a light shines through to provide a glimmer of hope. Several weeks ago Governor Ronald Reagan challenged Senator Edward Kennedy to debate the issue of National Health Insurance. This occurred at the National Governor's Conference when Kennedy made a pitch for his own federalized health plan. Senator Kennedy would not accept the challenge. So logical was Governor Reagan that I take the liberty to quote from him at some length.

He pointed out that 182 million Americans already have some kind of medical insurance, 19 million receive Medicaid benefits and 20 million are eligible for Medicare. He inquired "Who asked for this nationalized health insurance? I find no evidence that there is great public demand."

"Furthermore," the governor continued, "who has determined that national health insurance will work when experience in other countries has shown that it doesn't?"

The questions raised by the great California Governor are extremely pertinent. What is more important, they demand an answer. Others try to ignore them.

Their logic is proven by a recent release of a two-year study by the Rand Corporation. The study predicts that a federalized full-coverage health plan would increase demands for so-called ambulatory services by 75 percent.

As a result of this increased demand that would far exceed the current capacity of the present system, several things could be expected to happen. There could be delays in obtaining doctor appointments, there could be an increase in the waiting time at the office or

clinic and a change in the quality of services rendered. There could be an increase in costs. Lack of incentive by governmental interference could result in doctors working fewer hours. Even though continuing to work full time as before, doctors could not manage to handle the increased volume, since it is now quite well known that almost all doctors are seeing the maximum number that can be taken care of properly.

The introduction in Montreal of a full-coverage national health care plan caused a near doubling of waiting days to see a doctor. This delay could result in permanent harm to people with serious illnesses.

The Rand report also indicated that increased demand would cause a more rapid turnover of patients with an abbreviation of time devoted to any one patient. This change could have the undesirable effect of allowing treatable disease to be overlooked — something that would be viewed by both health professionals and the public as a degradation in the quality of health care.

The Rand study further points out that "a substantial investment in the delivery of more health services is not likely to produce any clearly measurable change in any dimensions of health, whether in length of life or physical well being." Social factors responsible for premature death such as poverty, smoking, alcoholism and automobile accidents are little effected by health services.

The burden of proof is on those advocating national health insurance. Thus far, they have failed to make a compelling case for their cause. It would appear their interest is more political than social.

*J. S. Richardson, M.D.*



# Extracranial Pituitary Surgery: A Revival of an Operative Approach

RICHARD V. SMITH, MD  
RAYMOND O. SMITH, MD  
GUY O. DANIELSON, MD  
P. A. ROBERTS, PHD  
ROBERT G. FISHER, MD  
ALBERT L. RHOTON, MD

*Transsphenoidal hypophysectomy has been re-introduced and developed as a safe and probably superior method of intrasellar pituitary surgery. An operative case of acromegaly illustrates the procedure. The approach has been especially adaptable to patients with metastatic carcinoma requiring endocrine ablation for palliation.*

Access to the sella turcica represents a formidable anatomical and surgical problem. From its beginnings in 1893, pituitary surgery for adenoma developed along two lines. The first constituted the intracranial approach as proposed by Caton and Paul in 1893, and performed shortly thereafter by Sir Victor Horsely in England, Krause in Berlin, and McArthur in the United States.<sup>3,8</sup> Frazier in 1913 modified the approach, thereby providing the basic transfrontal approach used today.<sup>8</sup> The second approach, as suggested by Kroening in Vienna in 1898, utilized an oronasal transsphenoidal route to the sella.<sup>3</sup> Using a disfiguring trans-

nasal procedure, the transsphenoidal operation was first performed by Schoffler in Vienna in 1906. In March of 1909 Hirsch in Vienna developed a less disfiguring submucosal transseptal modification.<sup>9</sup> Similar development was underway in the United States at Northwestern Medical School, Chicago, where Kanavel approached the sphenoid and sella turcica in a cadaver via a small infranares incision.<sup>10</sup> Halstead (1910) proceeded with the oronasal submucosal technique in a living patient; however, the procedure required staging because of blood loss with removal of the turbinates, ethmoid and vomer.<sup>3</sup>

In 1914 Harvey Cushing, at the Brigham Hospital, combined the various techniques mentioned above and developed the ororhinoseptal transsphenoidal hypophysectomy as we know it today. (Fig 1)

Doctor Cushing utilized the transsphenoidal route for access to pituitary adenomas in 74% of his cases from 1913 to 1932. He reported a mortality rate of 5.3% in 247 cases.<sup>1,7</sup>

All was not sublime, however, in extra-cranial pituitary surgery. The operative field offered restricted exposure and limited working space. Occasional incomplete tumor removal in some patients resulted in early symptom recurrence. Reported disadvantages of the transsphenoidal route mounted until the mid 1920's when the mortality rate from meningitis alone reached 25%. Dandy and Adson in 1920, advocating Frazier's transfrontal approach to the

From the Division of Neurological Surgery, Department of Surgery; Department of Otorhinolaryngology, Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, and the Department of Neurosurgery, Gainesville, Florida.



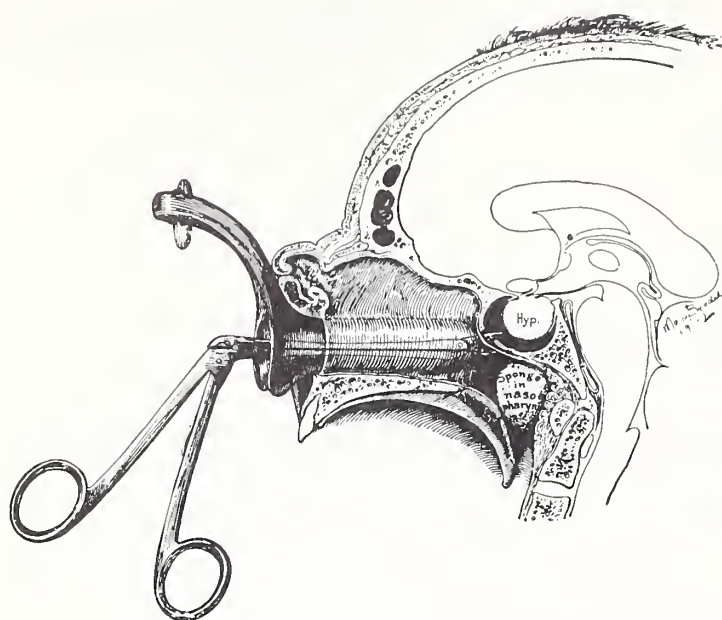


Figure 1. 1914 Ororhinoseptal transsphenoidal technique utilized by Harvey Cushing which is essentially the same method and basic instrumentation used today. (Reproduced with permission from JAMA 63, 1515, 1914)

pituitary, condemned the mortality rate from the transsphenoidal approach with its inherent limitations, and a trend away from the extracranial route began. By 1931 the 31 members of the Society of Neurological Surgeons overwhelmingly favored the transfrontal approach to the sella.<sup>8</sup>

Despite shortcomings, the extracranial approach to the pituitary offered the following advantages: the operative trauma was less and, discounting meningitis, the morbidity was lower than with intracranial procedures. Transsphenoidal hypophysectomy also left the suprasellar structures and cerebral hemispheres undisturbed. For a neoplasm restricted to the sella and for extracranial extensions of tumor, the transsphenoidal approach appeared ideal.<sup>4, 7</sup>

Reinstitution of extracranial pituitary surgery as an acceptable procedure awaited three technological advances. The first was the advent of the antibiotic era, and the second was development of televised x-ray image intensification. A third development was employment of the operating microscope.

With the availability of antibiotics, Hamlin (1945) advocated a return to the transsphenoidal route in 104 patients from 1945 to 1962 and experienced a mortality rate of less than two percent. However, sentiment contin-

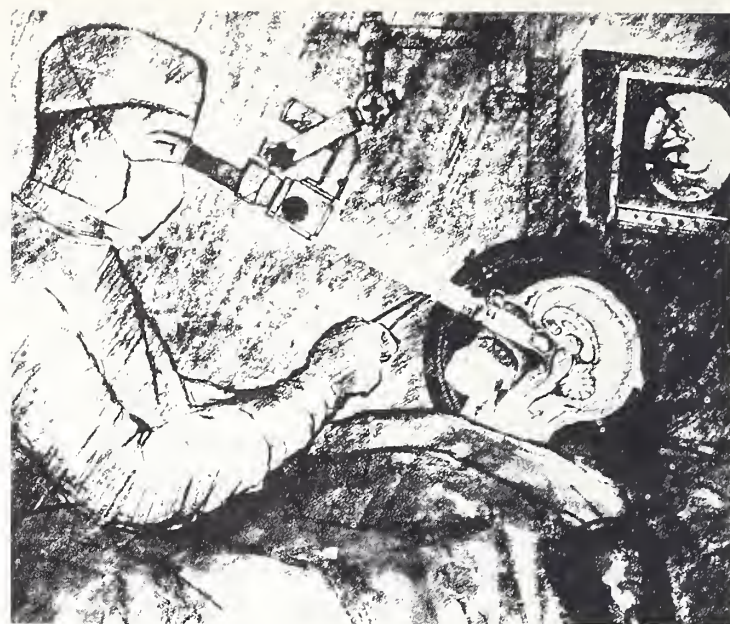


Figure 2. Illustrating the current operating room technique for ororhinoseptal transsphenoidal pituitary surgery using the operating microscope and televised fluoroscopy. (Reproduced with permission from L'Union Medicale du Canada)

ued to run high against the transsphenoidal approach, and in 1962 the Harvey Cushing Society's Symposium on Pituitary Tumors continued condemnation of extracranial pituitary surgery.<sup>4</sup>

By 1960 use of televised fluoroscopy and the operating microscope (Fig 2) allowed Jules Hardy of the Notre Dame Hospital, Montreal, Canada, to reintroduce extracranial pituitary surgery, utilizing Harvey Cushing's basic 1914 technique and instrumentation. In 1965 Hardy presented 20 cases of pituitary tumors operated through the oronasal transseptal route with no deaths. One patient developed aseptic meningitis associated with a cystic craniopharyngioma. It appeared that the risk of sepsis was no greater than with entrance into the frontal sinus during transfrontal craniotomy. Hardy's experience increased and in 1968 he reviewed 150 cases operated transsphenoidally with no deaths and no cases of meningitis. Thus, extracranial pituitary surgery with its aforementioned specific advantages and the improvements in instrumentation has regained acceptance and is now becoming an accepted procedure in many centers.<sup>5, 6</sup>

The ororhinoseptal transsphenoidal route to the sella turcica has recently been instituted at the University of Oklahoma Health Sciences Center in selected cases of intrasellar tumor and for pituitary ablation in metastatic carcinoma of the breast. The following case report describes such a procedure.



A 27-year old white man developed signs and symptoms of acromegaly in 1967. Skull and sella turcica roentgenograms revealed no abnormalities. Carotid arteriography and visual fields were normal. Urinary 17-hydroxy and

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17-ketosteroids, and thyroid function studies were normal. Growth hormone assay was not available. A right transfrontal craniotomy was performed in 1967, and a prefixed optic chiasm was encountered which precluded adequate intrasellar exploration and tumor removal. A sub-total hypophysectomy was performed. Postoperatively the patient experienced transient diabetes insipidus, and he has required cortisone acetate, thyroid and androgen replacement therapy. Symptomatically the patient did not improve and subsequent post-operative growth hormone assays remained elevated.

In December, 1973, utilizing televised fluoroscopy and the Zeiss operating microscope, an ororhinoseptal transsphenoidal exploration of the pituitary fossa was performed. Tumor was found filling the sella turcica and under operative magnification the entire tumor mass was removed. Antibiotics were employed and, postoperatively, the patient was awake and conversant in the recovery room and required minimal analgesia. He was sitting and eating by evening of the day of surgery, and was ambulatory the following day. The patient was discharged from the hospital on the seventh post-operative day and has experienced marked reduction in his acromegalic symptoms and in his clothing size. A two-month follow-up visit revealed continued symptomatic improvement. His pituitary replacement therapy has been managed easily.

#### DISCUSSION

Currently transsphenoidal hypophysectomy is employed to remove intrasellar pituitary tumors or to perform pituitary ablation. Growth hormone producing adenomas, basophilic microadenomas associated with Cushing's disease, and chromophobe adenomas all allow transsphenoidal removal as long as the neoplasms do not extend too far above the sella turcica. Supracellar extension, seen with large chromophobe adenomas and with most craniopharyngiomas, may necessitate a transfrontal approach because of associated third ventricle, optic chiasm, and carotid artery involvement.

Pituitary ablation has been used in the therapy of metastatic breast carcinoma, metastatic prostatic cancer and progressive visual loss associated with diabetic retinopathy. When used for the palliation of patients with breast carcinoma, hypophysectomy has proved most beneficial for premenopausal women who dis-



played tumor remission after oophorectomy, and for postmenopausal subjects. A prolonged symptom-free interval between mastectomy and tumor recurrence, and certain loci of metastatic disease favor a good response from pituitary ablation. As high as an 80% remission rate for up to 18 months has been reported in carefully selected patients. The remission rate drops to about 40% when less stringent patient selection criteria are applied.<sup>2,11,13</sup>

Patients with metastatic prostatic carcinoma are most likely to develop a remission if they responded initially to orchiectomy. About 50% of the aforementioned patients experienced reduced bone pain and showed decreased tumor size with an average remission lasting up to eight months.<sup>12,13,14</sup>

When utilized for the treatment for diabetic retinopathy, hypophysectomy has proved most beneficial for those patients without renal impairment in whom diabetes control cannot be improved. When the visual loss results primarily from retinal hemorrhage and if local ophthalmologic procedures such as photo coagulation have not been successful, pituitary ablation can be employed in an effort to stabilize the patient's remaining visual acuity.<sup>12,13</sup>

Hormonal replacement therapy following transsphenoidal pituitary surgery is managed utilizing cortisone acetate, thyroid and in the appropriate patient, androgen or estrogen. The incidence of permanent postoperative diabetes insipidus is 40% or less, however, the use of pitressin tanate in oil or Diaped nasal spray can minimize this phenomenon.<sup>5</sup>

Endocrine ablation by adrenalectomy for carcinoma of the breast has provided remission rates similar to those achieved with hypophysectomy. Adrenalectomy has generally been preferred in the past; however, renewed utilization of the transsphenoidal approach to the pituitary has markedly decreased the morbidity of an ablative procedure and provided an acceptably low (less than 1%) mortality rate. Patients who undergo transsphenoidal hypophysectomy complain of minimal postoperative pain and can usually leave the hospital on the eighth or ninth day after surgery. Thus, pallia-

tion can be achieved for many patients by a procedure which causes minimal morbidity and which carries a very low mortality rate.<sup>2,5</sup>

## SUMMARY

A case of acromegaly due to a growth-hormone-producing pituitary adenoma limited to the sella turcica is presented. Our patient's tumor was removed by the transsphenoidal approach to the pituitary gland. The extracranial or ororhinoseptal transsphenoidal approach to the sella turcica, proposed in 1893 and performed in the early 1900's has been revived and has been accepted as a safe and probably superior method for intrasellar pituitary surgery. Hormonal replacement therapy can be managed with relative ease in responsible patients. The minimal morbidity and extremely low mortality rate associated with transsphenoidal hypophysectomy make it an excellent palliative procedure for properly selected patients with breast or prostatic carcinoma. Patients with progressive diabetic retinopathy which is not controlled by medical or ophthalmologic therapy may also receive benefit from transsphenoidal pituitary ablation.

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# Hyperalimentation in Infants and Children

DAVID P. CAMPBELL, MD  
EDWIN IDE SMITH, MD

*Parenteral hyperalimentation has become a useful surgical adjunct in infants and children with acute and chronic diseases of the gastrointestinal tract.*

This report is based upon an experience with over 100 infants and children who have received parenteral hyperalimentation at Oklahoma Children's Memorial Hospital.

## HISTORY

Dudrick and his associates<sup>1</sup> in 1967 first reported that it was possible to provide sufficient protein, calories, minerals and vitamins by the intravenous route to maintain a positive nitrogen balance and promote normal growth and development.

The basic physiologic principles used by Dudrick were outlined earlier by Moore<sup>2</sup> when he

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again drew attention to the fact that a minimum of 120 to 150 non-protein calories per gram of parenteral nitrogen (1 gm nitrogen = approximately 7 gms of protein) were necessary for protein synthesis to take place. When protein hydrolysates are infused without sufficient non-protein calories the amino acids in the hydrolysate are deaminated and oxidized for energy.

The components of the standard hyperalimentation solutions have been available for many years. Twenty percent dextrose solutions, (the caloric source in hyperalimentation fluid) could previously never be used effectively because of their hypertonicity and tendency to cause rapid thrombosis of peripheral veins. They also have a tendency to cause hyperglycemia and a secondary osmotic diuresis.

Protein hydrolysate solutions have also long been available. Before Dudrick's work,<sup>1</sup> however, they enjoyed little popularity because of their inability to increase lean tissue mass when administered with the insufficient calories contained in 5% dextrose solutions.

Dudrick's group<sup>1</sup> solved the problems inherent in the intravenous delivery of high concentration glucose solutions combined with 5% protein hydrolysates. The method they devised includes the use of central venous catheters and continuous infusion techniques using peristaltic pumps. Central venous infusion allows for rapid dilution of the concentrated glucose solu-



tion by high volume blood flow thereby eliminating the problem of peripheral phlebitis. A slow, constant, 24-hour infusion prevents the hyperglycemia, glucosuria and diuresis seen when such solutions are infused intermittently at faster rates. The endocrine pancreas of the individual receiving hyperalimentation fluid adjusts rapidly to the glucose load with a markedly increased insulin secretion.

We have found hyperalimentation in the pediatric age group to be most useful in treating chronic idiopathic diarrhea, short-gut syndrome secondary to intestinal resection, bowel dysfunction secondary to gastroschisis or omphalocele and enterocutaneous fistulae. In all of these conditions hyperalimentation allows one to put the gut at complete rest while providing adequate calories and protein for normal growth and development.

#### MECHANICS OF HYPERALIMENTATION IN INFANTS AND CHILDREN

Barium-impregnated silastic catheters are used to deliver the hyperalimentation solution. They are inserted into the superior vena cava via an internal or external jugular vein cut-down. The cut-down is done under local anesthesia. It is performed in the operating room to assure aseptic conditions. (Figures 1, 2) In children over four years of age, we insert the catheter by direct percutaneous puncture of the subclavian vein. This can be done on the ward; but once again, strict aseptic techniques are used. We always confirm proper placement of the catheter in the superior vena cava by chest x-ray.

Upon proper placement of the catheter, we begin an infusion of 10% dextrose in water and apply an occlusive dressing. (Figure 3) A chest x-ray is obtained two hours later to rule out leakage of the infusion into the pleural cavity through a lacerated vein. If all is well, an infusion of our standard hyperalimentation solution is started at a rate of approximately 100 cc per kg/24 hours. (Figures 4, 5) We then gradually increase the rate daily to a maximum of approximately 140 cc/kg/24 hours. Our standard hyperalimentation fluid contains approximately 0.9 calories per cc. We initially check the urine glucose at every voiding and adjust the rate of flow accordingly. The flow rate is decreased only if the urine glucose reaches



Figure 1. Infant prepared for insertion of hyperalimentation catheter via jugular vein.

three to four plus. Because of the dangers inherent in using insulin in neonates and young infants we do not treat hyperglycemia or glucosuria with insulin as is common practice in adults receiving hyperalimentation. Hyperglycemia and glucosuria in our pediatric patients are treated solely by decreasing the infusion rate.

CBC, serum bilirubin, serum proteins and electrolytes are obtained weekly after starting



Figure 2. Post insertion of hyperalimentation catheter in jugular vein.





Figure 3. Occlusive dressing over hyperalimentation catheter site.

the infusion. Plasma or whole blood (20 cc/kg) is given once per week with plasma alone being administered if the hematocrit is 35% or greater.

#### CARE OF THE CATHETER

We change the occlusive dressing over the catheter site (Fig 3) every three days. Strict aseptic techniques are used. The skin is first defatted with acetone and then painted with Betadine® solution. Betadine® ointment is placed on the skin around the catheter entrance site.

® — Purdue Frederick Co., Norwalk, Connecticut

Figure 4

#### OCMH Standard Hyperalimentation Fluid

400 cc	D <sub>5</sub> /5% hydrolyzed protein solution
250 cc	D <sub>50</sub> W
20 mEq	NaCl
25 mEq	K <sub>2</sub> PO <sub>4</sub>
20 mEq	Ca gluconate
10 mEq	MgSO <sub>4</sub>
1 cc	MVI multivitamins
0.5 mg	Folic Acid
1 mg	Vitamin K <sub>1</sub>
1 µg	Vitamin B <sub>12</sub>

Figure 4. Oklahoma Children's Memorial Hospital standard hyperalimentation fluid.

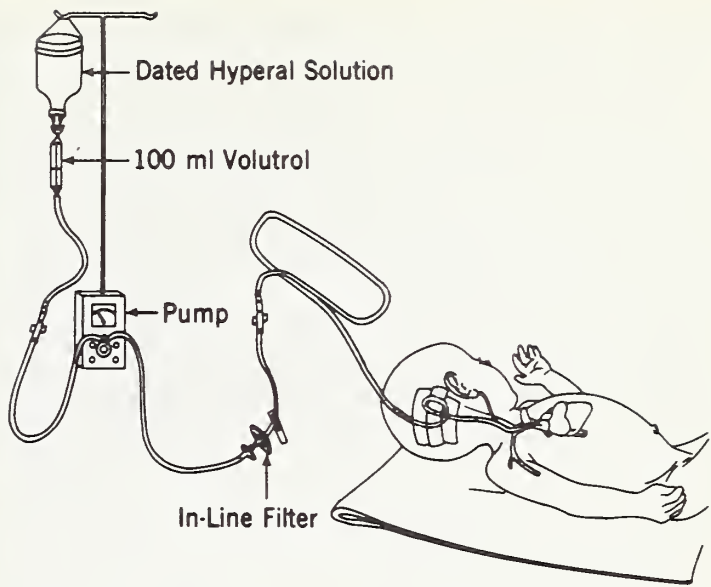


Figure 5. Setup for administration of hyperalimentation fluid.

To decrease the possibility of contamination, we insist that blood not be drawn from the catheter nor medications or blood be given through the catheter.

#### COMPLICATIONS

Hyperalimentation is not a benign procedure. The indications for its use must therefore be quite stringent. The most common complication of hyperalimentation is bacterial or fungal sepsis. Because of the low pH and high osmolarity of hyperalimentation solutions, bacterial contamination of the solution itself is quite rare. Fungi, however, especially *Candida*, will grow in the solution. We are, therefore, always on the alert for both bacterial and fungal sepsis. The first signs of sepsis may be either fever or hypothermia. Glucosuria after an interval of negative urine glucose determinations also suggests sepsis. When sepsis is suspected, the hyperalimentation line is opened at the proximal catheter connection and a blood culture obtained. The hyperalimentation solution is taken down and cultured. The urine and nose and throat are also cultured. We then switch to a ten percent dextrose solution infusion until the results of all cultures are available. We formerly removed all catheters upon any suspicion of sepsis. We soon found, however, that many catheters were being needlessly removed for signs and symptoms that were not due to sepsis. The replacement of a hyperalimentation catheter in an infant can be a time consuming and often difficult surgical procedure.



## Hyperalimentation / *Campbell, et al*

Sepsis is usually secondary to a septic thrombus on the tip of the hyperalimentation catheter. It clears rapidly upon removal of the catheter. Antibiotics are usually not required. One should never stop a hyperalimentation infusion "cold turkey." After discontinuing the hyperalimentation fluid one should begin an infusion of 10% glucose in water. This prevents rebound hypoglycemia which results from the markedly increased secretion of insulin stimulated by the hypertonic glucose solution.

An osmotic diuresis with secondary dehydration can be caused by too rapid an infusion of hyperalimentation solution. This can be prevented by infusing at a slow steady rate over a 24-hour period. We advise our nurses not to attempt to catch up if they fall behind with the hourly infusion rate. This can cause a sudden hyperglycemia and osmotic diuresis.

In the early experience with hyperalimentation, a generalized maculopapular rash often developed after several weeks of therapy. The cause is still undetermined, but it is hypothesized that it is secondary to a trace element or essential fatty acid deficiency. This general cutaneous reaction can be prevented by the weekly infusion of either plasma or blood. We obtain a hematocrit on each patient once a week and if the hemato-

crit is less than 35% we infuse 20 cc/kg of whole blood. If the hematocrit is higher than 35% we infuse 20 cc/kg of plasma.

Children receiving hyperalimentation therapy will show a slow but steady decrease in their red cell mass. This is thought to be secondary to hemolysis at the catheter tip where the red blood cells come into contact with the hypertonic solution. Actual evidence of hemolysis, however, is difficult to prove. This slow but progressive decrease in red cell mass makes blood transfusions a necessity. As noted above we give blood or plasma weekly.

### OTHER USES OF HYPERALIMENTATION

#### Primary Therapy of Inflammatory Bowel Disease

Hyperalimentation allows one to place the bowel at complete rest while maintaining adequate nutrition. Hyperalimentation has been tried as primary therapy in both ulcerative colitis and regional enteritis.<sup>3</sup> No cures or prolonged remissions have been reported with the use of hyperalimentation in the treatment of ulcerative colitis. We therefore use it primarily as a supportive measure prior to definitive surgical treatment.

A significant number of short term remissions have been reported with the use of hyperalimentation in regional enteritis. We have found it especially useful in children with recurrent symptoms and widespread disease in whom resectional surgery is inadvisable.

#### Adjunct to Chemotherapy in the Treatment of Solid Tumors:

Hyperalimentation has proved useful when used in conjunction with chemotherapy in the treatment of disseminated solid tumors of infancy and childhood. The new combined chemotherapy protocols compound the gastrointestinal side effects of the individual drugs. Anorexia, vomiting, diarrhea and stomatitis all lead to a state of semistarvation and negative nitrogen balance. They can force discontinuation of the chemotherapy. The gastrointestinal side effects of chemotherapy will improve if the bowel is put at complete rest with intravenous hyperalimentation. This will often allow for continuation of the chemotherapy.

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One must be especially wary of sepsis in the patient being treated with chemotherapy and hyperalimentation. Most such patients have depressed bone marrows and are severely neutropenic.

THE FUTURE OF HYPERALIMENTATION

The future of hyperalimentation is dependent upon approval by the Food and Drug Administration of recently developed intravenous fat emulsions such as Intralipid®. Fat emulsions will eliminate many of the problems inherent in the use of hypertonic glucose solutions as the caloric source in hyperalimentation. Intralipid® has now been used in Europe for several years and has been shown to be quite safe. There have been none of the problems seen with fat emulsions previously used in this country.

The major advantage of fat emulsions is

that they are not markedly hypertonic and can be given via a peripheral vein. The problems of phlebitis, hyperglycemia and osmotic diuresis are therefore eliminated.

When fat emulsions are commercially available they will become the caloric source of choice for use with hydrolized protein solutions in intravenous hyperalimentation. The use of hypertonic glucose solutions in intravenous hyperalimentation will then become of only historical interest.

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## News From The Oklahoma State Department of Health

The Tuberculosis Advisory Committee and special consultants recently met at the Center for Disease Control to re-examine the problem of isoniazid-associated hepatitis.

The group concluded that liver disease does occur in patients receiving isoniazid (INH) preventive therapy. Age is the predominant factor that seems to increase the risk of liver disease. Therefore, in positive tuberculin reactors 35 years of age and over, the risk of hepatitis precludes the *routine* use of preventive therapy. If additional risk factors are present, preventive therapy is indicated regardless of age. For positive tuberculin reactors under 35, the benefit of preventive therapy outweighs the risk of hepatitis, even in the absence of other risk factors.

Daily use of alcohol may increase the risk of INH-associated hepatitis. The development of hepatitis in any given patient cannot be pre-

dicted. Routine liver-function tests are not useful and are not recommended. Liver disease cannot be linked to any particular manufacturing process or contaminant.

Persons with the following additional risk factors are generally recommended for preventive treatment: (1) Household members and close associates of persons with active disease, (2) positive tuberculin reactors with inactive tuberculosis without a history of adequate treatment, (3) newly infected persons (tuberculin converters), and (4) positive reactors with certain medical conditions, *eg*, silicosis, diabetes mellitus, gastrectomy, and immunosuppression from many causes.

Contraindications to INH preventive therapy are: (1) Previous INH-associated hepatitis, (2) severe adverse reactions to INH, and (3) acute liver diseases of any type. Pregnancy is considered a contraindication to preventive therapy unless the patient has additional risk factors.

Those for whom preventive treatment is not contraindicated but who should be carefully observed are persons taking other medications (especially Dilantin), daily users of alcohol, those with chronic liver disease, and those who have previously discontinued INH because of possible side effects. □

### COMMUNICABLE DISEASES IN OKLAHOMA FOR JULY, 1974

DISEASE	July 1974	July 1973	June 1974	Total To Date 1974	1973
Amebiasis	4	6	3	14	20
Brucellosis	2	1	2	6	3
Chickenpox	11	26	94	800	1293
Encephalitis, Infectious	8	36	16	39	63
Gonorrhea (Use Form ODH-228)	1204	1045	907	6421	6349
Hepatitis, A, B, Unspecified	78	81	78	643	678
Leptospirosis	—	—	1	1	—
Malaria	2	1	—	3	2
Meningococcal Infections	2	10	1	14	25
Meningitis, Aseptic	11	25	7	37	48
Mumps	8	40	42	358	412
Rabies in Animals	11	8	22	97	133
Rheumatic Fever	—	1	—	7	10
Rocky Mountain Spotted Fever	18	17	18	46	62
Rubella	3	10	4	36	177
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	1	2	4	24	51
Salmonellosis	27	31	12	141	122
Shigellosis	13	29	19	88	139
Syphilis, Infectious (Use Form ODH-228)	13	13	4	87	109
Tetanus	—	—	—	—	3
Tuberculosis, New active	41	27	35	194	181
Tularemia	4	5	3	10	18
Typhoid Fever	1	—	—	1	2
Whooping Cough	4	4	2	12	18



### He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply prints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. I go without saying that a physician should also rely on other sources for his information on pharmacology.

### Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce — information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

### Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just "pushers" of their drugs.

### The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love — they are in the business of selling products for profit. In this regard ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

### Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

### Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.



## OSMA Launches Health Sciences Center Campaign

An information campaign to assist and aid the beleaguered Oklahoma University Health Sciences Center has been undertaken by the OSMA's Board of Trustees. The campaign, financed by \$5,000 from the association plus contributions from association members, will cover the entire state in order to call attention to the financial condition at the center.

Jack L. Richardson, MD, President of the OSMA, appointed C. S. Lewis, Jr., MD, Chairman of the Association's Medical Center Liaison Committee, as coordinator of the statewide project.

Doctor Lewis is working with a Tulsa public relations specialist, Mr. Chuck Schnake, to develop the informational program. Numerous meetings were held throughout August with various high level officials with the University, University Hospital, OU College of Medicine, and other state officials in order to formulate specific suggestions to solve the problems of the health sciences center.

The problems of the center, along with the suggested solutions, will be presented at public meetings held throughout the state during the last half of September and throughout October.

Special invitations to attend the public meeting will be extended to all physicians and their families in each area. Invitations will also go to public officials, community leaders, and allied health care personnel.

On August 7th a public statement was issued by Doctors Richardson and Lewis regarding the health sciences center. The statement was released simultaneously in Oklahoma City and Tulsa and received extensive coverage in the press and on radio and television. It outlined the association's philosophy and plans for the information campaign.

The public statement was as follows:

"The University of Oklahoma Health Sciences Center has been a declared crisis for more than two years now, gaining page-one headlines throughout the state. During this

period there have been countless investigations, studies, controversies, accusations and resignations. And the headlines are continuing.

"We believe that some of this attention has been helpful but that much of it has been totally undeserved.

"The problems of the health sciences center did not appear overnight. They have been developing over a period of years . . . years which have been a reversal of federal funding practices, years which have seen the evolution of new concepts in health care delivery.

"The developing financial plight of the center was for too long ignored both by the leadership of the center and by the executive and legislative branches of state government. For too long there has been a climate of mutual distrust between the center and the state capitol.

"The health sciences center has had major financial and fiscal management problems. But these problems must not be permitted to jeopardize the quality of medical education. We agree that the health sciences center must be operated within the state system of higher education. We agree that it must be fiscally responsible and accountable for its funds and its programs. We expect that from every institution. We believe that new management systems have been and will be more effective, and we applaud this progress.

"Yet it has been implied by some political voices that the staff and faculty of the center have bordered on the illegal. These implications could well be felt later in attempts to recruit new and outstanding faculty members and they could ultimately effect the quality of medical care delivered to all Oklahomans.

"We believe this prolonged crisis was caused by a lack of foresight on the part of political leadership. In 1968, Oklahomans approved the Hero Bond issue which provided a major expansion of the health sciences center through construction of new hospital and teaching facil-



ities. Yet, past legislatures failed to recognize that with expansion and growth come higher operating costs.

"Another major cause for the crisis has been this state's inability to recognize and resolve the question of who pays for indigent care. The State of Oklahoma has no efficient, planned program to handle this massive problem. We believe it's time for state leaders to confront this problem head-on and that it should be one of the most important programs facing the next legislative session.

"We believe that the cost of caring for the medically indigent should not be borne by higher education, nor by the paying patients at private hospitals, but should be borne by all Oklahomans on a just basis in a statewide program.

"Our principal concern is not with the past, but with the immediate and long-range future. Our concern is that medical education in Oklahoma be maintained at a level which will insure first class health care for the people of this state.

"As Doctor Don O'Donoghue said in a report to Governor Hall in 1972, 'Indeed, the people of Oklahoma do not want and cannot afford second class health education or second class health care.'

"We believe the State of Oklahoma has been receiving better medical education than the state has been willing to pay for. The people of this state have clearly expressed on many occasions their desire for more physicians and health-related personnel. They have expressed their willingness to pay for more and improved health care delivery.

"The health sciences center, despite limited funds, has made and is making great strides every day to give the people what they have asked for. There are more students at the center than ever before and the quality of their education is not only adequate, it's excellent. It is a truly outstanding institution with many great achievements on its record, with a dedicated faculty composed of people who have given much of their professional lives to the growth and excellence of medical education. Regarding recent resignations, we know of no one who has left because of guilt or incompetence . . . but some have left because of frustration, extreme disappointment and the lack of public trust expressed through political voices.

"For too long there have been too few voices of support for medical education excellence

. . . only criticism. For too long there has been little or no understanding of the whole medical education process, of how it really works.

"We feel it is our role to speak up, to point out the strengths of our medical education system which leads to medical care for the people of Oklahoma.

"As a result, during the next few months we will take the documented story of the progress and the needs of medical education to the people of the state principally through a series of informational meetings. Specifically, we will confront the questions of indigent care costs, University Hospital's future, the quantity and distribution of physicians, and the quality and the costs of medical education.

"We are not idealistic enough to believe that this alone will turn the tide from criticism to support. But we are optimistic enough to believe that there are Oklahomans in agriculture, in business and industry, in education and in all walks who need to know that the health sciences center and medical education in Oklahoma is not sick, but in fact extremely healthy and in need of their active support.

"We ask that concerned citizens be aware of the need for their support in these efforts. And we ask our elected leaders to meet their responsibilities in supporting a system of health education excellence . . . for the sake of this and future generations of Oklahomans." □

## **Over \$900,000 Given In Aid To OU College of Medicine Students**

Medical students at the OU College of Medicine received over \$900,000 in assistance during school year 1973-74. The assistance took the form of scholarships, loans, and grants-in-aid.

Out of 555 students enrolled in the OU College of Medicine, 206 received assistance dispersed by the school itself. They received a total of \$403,915.

One hundred sixty-six students participated in the Health Professions Loans and Scholarship Program and received nearly \$250,000 in loans to be repaid. An additional 88 students received \$65,000 in direct scholarships.

Additional assistance was offered to students through the waiver of tuitions and fees and other scholarship funds.

Over one-half million dollars was dispersed to OU College of Medicine students by outside



organizations. The American Medical Association's AMA-ERF Loan Fund helped 17 students with \$22,900. One hundred three students received guaranteed bank loans amounting to \$157,936.

At the present time there are 45 students receiving Armed Forces Health Profession Scholarships to the tune of one quarter million dollars.

The Oklahoma State Medical Association Scholarship Fund expended \$20,000 on six students. These six young men have agreed to serve in rural communities one year for each year of aid they receive. Additionally, the Oklahoma Rural Scholarship Fund, created by the legislature, expended \$100,000 on 24 students who have made a similar agreement.

Medical school can be very expensive for some people. At the end of the 1973-74 school year a total of 24 students had already incurred financial indebtedness of \$15,000 or more. Eight of the students had not yet reached their fourth year of medical school.

The vast majority of all aid given to medical students takes the form of loan that must be repaid after the completion of medical training.

In the late 1950's the OSMA established a Loan and Scholarship Fund to aid medical students. The dues of the association were raised at that time in order that \$5.00 from each dues paying member could be put into a special fund. Approximately \$10,000 per year is used for this purpose.

Until 1970 the money was used for grants and small scholarships and loans. Since 1970, it has been transferred to the Foundation for Community Medical Care and used to finance the Rural Scholarship Program. Thus far the association has invested over \$57,000 in future physicians through this program.

Many of the loans that were made during the 1950's and 60's are now being repaid to the association. Most recently the school returned to the OSMA over \$7,000 in loan repayments. This money will be transferred to the Foundation for Community Medical Care and used to help finance more rural scholarships.

Each year the association conducts a voluntary fund raising drive for the OU College of Medicine. The monies received are turned over to the school and then used to procure federal matching monies at a rate of ten to one. Many thousands of dollars have been raised in the past few years for this purpose. □

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## South American Travel-Medical Workshop Announced

A 14-day air-sea cruise along the eastern coast of South America is being sponsored by the Oklahoma State Medical Association. Reservations are now being accepted on a first come, first served basis for the January 28th, 1975, departure from Tulsa and Oklahoma City.

The combination of exciting ports of call and comprehensive professional workshops add to the pleasure of traveling with colleagues and friends.

The tour will fly direct on a chartered Trans-International Airlines "stretch" DC-8 from Oklahoma City and Tulsa to Montevideo, Uruguay. The flight will be extraordinarily comfortable because the plane will have fewer seats than usual for extra leg room space. The meals are first-class with complimentary wines, and of course, an open bar.

In Montevideo travelers will board the *Stella Oceanis*, known as one of the finest luxury cruise ships in the world. She is unequalled for elegant accommodations, delicious cuisine and personalized service. The ship will be "home" while cruising along the "sunshine coast of South America."

The medical workshops, planned and organized by Seminars and Symposia, Inc. will offer an extensive program of pertinent educational material. The main theme for the seminar will be "Emergencies in Medical Practice." There will be 28 hours of classes, all scheduled to give the faculty members and participants ample time to develop the theme and not conflict with the enjoyment of visiting the fascinating places on the cruise. In addition to the accompanying faculty, arrangements have been made with local professors of medicine to conduct several of the workshops in port.

Membership in the cruise is limited. A deposit of \$150 is required to reserve space. Prices for the tour range from a low of \$995 for an inside state room to a high of \$1,895 for a deluxe suite.

Persons interested in the tour should contact the Oklahoma State Medical Association by telephone or a letter.

The itinerary for the tour is as follows:

January 29th arrival by air in Montevideo and transfer to the ship. Sail in the evening.

January 30th arrive Mar Del Plata, Argentina in the morning and sail in the evening.

January 31st early afternoon arrival in Buenos Aires, Argentina for an overnight stay.

February 1st afternoon sails from Buenos Aires.

February 2nd-4th cruising the South Atlantic to arrive at Santos, Brazil in the morning and spend the day in Sao Paulo. Sail in the evening.

February 5th dock in Rio de Janeiro, Brazil, in the morning. Overnight stay in Rio.

February 6th all day in Rio and sail in the evening.

February 7th arrival in the late morning at Vitoria, Brazil, and sail in the evening.

February 8th cruising the coast of Brazil.

February 9th. Early morning arrival in Salvador, Brazil, for an overnight stay.

February 10th. Depart Salvador by air in the morning to arrive in the USA that day. □

## Eckhardt, Parrish Appointed To Department of Family Practice

During its July meeting the OU Board of Regents appointed two new members to the Department of Family Practice at the University of Oklahoma Health Sciences Center.

Peter W. Eckhardt will serve as a special instructor in Family Practice and Community Medicine and Dentistry. Jack W. Parrish, MD, was appointed Clinical Assistant Professor of Family Practice and Community Medicine and Dentistry.

Doctor Parrish received his MD degree from OU in 1953. He is currently Chief of Staff at Seminole Municipal Hospital and Chairman of the Oklahoma Association of Family Practitioners Liaison Committee for the Family Practice Residency Programs and Family Medicine Clinic. He has also served as a President of the Oklahoma Chapter of the American Association of Family Practitioners and as a Delegate to the Oklahoma State Medical Association's House of Delegates. He is a certified board member of the American Board of Family Practitioners.

Mr. Eckhardt attended Saint Ambros College in Davenport, Iowa, and received a BS Degree in Zoology from Central State University in Edmond. He completed a Bachelor of Health degree at OU in 1973 and has acted as a physicians associate instructor at the Veteran's Administration Hospital in Muskogee. He is a native of Frankfort, Germany. □



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## Child Abuse Concern of New Pediatrics Director

Prevention of child abuse and proper therapy for parents who abuse their children are two areas of major concern to the new director of Pediatrics at the Oklahoma State Department of Health.



Jerry R. Nida, MD, 39, who began his duties as pediatrics director May 1st, stressed the importance of therapy in helping parents cope with their children. He urged families to seek help, through their local guidance center or other mental health professionals before their problem manifests itself in violence toward the child.

Current state law states that medical persons must report instances of child abuse. At the same time it states that "Every other person having reason to believe that a child under the age of 18 years has physical injury or injuries inflicted upon him or her by other than accidental means" should report this information to the county office of the Welfare Department, the county sheriff or the district attorney.

"Abusers used to be treated as criminals," Nida said, "but we now know that the act of abusing their child is only a manifestation of their own problems. These people need proper guidance and counseling to help them cope with these problems." He explained, "Usually when a catastrophe happens in this family — the car is repossessed, prices go up, the father loses his job — the child is low man on the totem pole and gets the brunt of the punishment."

Nida noted that there is a high incidence of juvenile delinquency among children who have been abused. "That is why it is so important to reach the whole family before the problem becomes severe," he said.

Another area of interest to the new pediatrics director is improving the system of screening and reporting phenylketonuria (PKU) in newborn infants. PKU is an inherited trait causing improper metabolism of amino acids. Untreated, it can result in mental retardation.

A blood test for PKU is given to newborn infants in Oklahoma hospitals. The specimens

are sent to the health department's laboratory for testing and the health department reports any abnormalities to the physician who then should request a more precise test—a fluorometric test.

Beginning in June the health department was equipped to perform the fluorometric test, thus saving several weeks in determining the presence of PKU. This means that the child will begin receiving treatment earlier — from two to five weeks of age.

Nida urged all hospitals doing the original PKU test themselves to send in the results immediately instead of saving them and sending them all at one time.

The physician pointed out that one out of every 15,000 to 20,000 babies have PKU. "Just because the first Guthrie Test is positive doesn't mean that the child has PKU," he added.

The new director of pediatrics has a wide range of interests and responsibility. He is also concentrating on centers for poison information, educating parents in child safety, detecting and eliminating dangerous toys and other common hazards, and setting a viral surveillance program to keep private physicians informed on current epidemics and their symptoms. □

## Family Practice Residency Increases Proposed

A proposed development of "satellite" family practice residencies, if adopted by the OU Board of Regents and the State Regents for higher education, could be an important step toward significantly increasing the number of rural Oklahoma Family Practice physicians.

The proposal, written by an ad hoc study committee of the Faculty Board of the OU Health Sciences Center, calls for the establishment of branch or satellite residency programs in family practice to be located in moderate sized communities throughout the state, with supportive day clinics located in surrounding "physicianless" communities.

Originally the ad hoc committee proposed that Enid be the site of the first such satellite residency program beginning this fall. Unfortunately, problems in approving, funding and implementing the program have caused delays. Communities the size of Lawton, Ardmore, Shawnee, Muskogee and McAlester are



also being considered for residency sites.

A college of medicine physician manpower study, which provided base data for the proposal, indicated there is "an overall minor deficiency of numbers of physicians in the State of Oklahoma," but that the principal problems with physician manpower in the state are ones of "geographic and specialty mal-distribution."

Currently Oklahoma has only 85 first-year residency positions available for its medical school graduates, who will number approximately 200 when OU's Tulsa Medical College is in full operation. Unless the number of residencies in the state is significantly increased, the proposal says, "all but 85 of these (200) graduates must go out of the state to continue their mandatory education, and many of these will never return."

The proposal has requested educational and general monies to support the program be made available to the college of medicine by July 1st, 1975, over and above that which will be requested for the operating budget of the college. As proposed, such monies will be requested from the state regents although alternative methods, such as local community financing, may be studied.

As made available, part of the funds would pay the stipend of six additional first-year residents in family practice, and each year the number of residents funded would be increased by six until an additional 24 residents were being trained. Currently, 21 family practice residencies are funded for next year, 17 at the Health Sciences Center through state and federal funds and four in Tulsa by the Tulsa Medical Education Foundation.

Total cost of the fully implemented, five-site program, including all the health care and educational experiences, will be approximately \$1.5 million. However, income generated by the operation of the site clinics is expected to offset almost one million dollars of that amount. Since the satellite residencies are educational in nature, they can never be completely self-supporting. There will always be that portion of operational costs devoted to educational activities.

Thomas Lynn, MD, Chairman of the ad hoc committee and acting Dean of the OU Medical School said, "... we feel the benefits of this program will be more than worth the money in

terms of immediate and future care for rural Oklahomans." □

## **Heart Association Announces Grants-In-Aid**

The Oklahoma Heart Association, Inc. has announced that applications for research grants-in-aid and postdoctoral research fellowships for the year beginning July 1st, 1975, are now being accepted for review by the Research Committee.

Application forms may be obtained from the Heart Association office and must be received no later than November 1st, 1974. Contact the Oklahoma Heart Association, Inc., 800 N.E. 15th Street, P.O. Box 11376, Oklahoma City, Oklahoma 73111. □

## **Representatives Will Attend AAMA Meeting In Denver Soon**

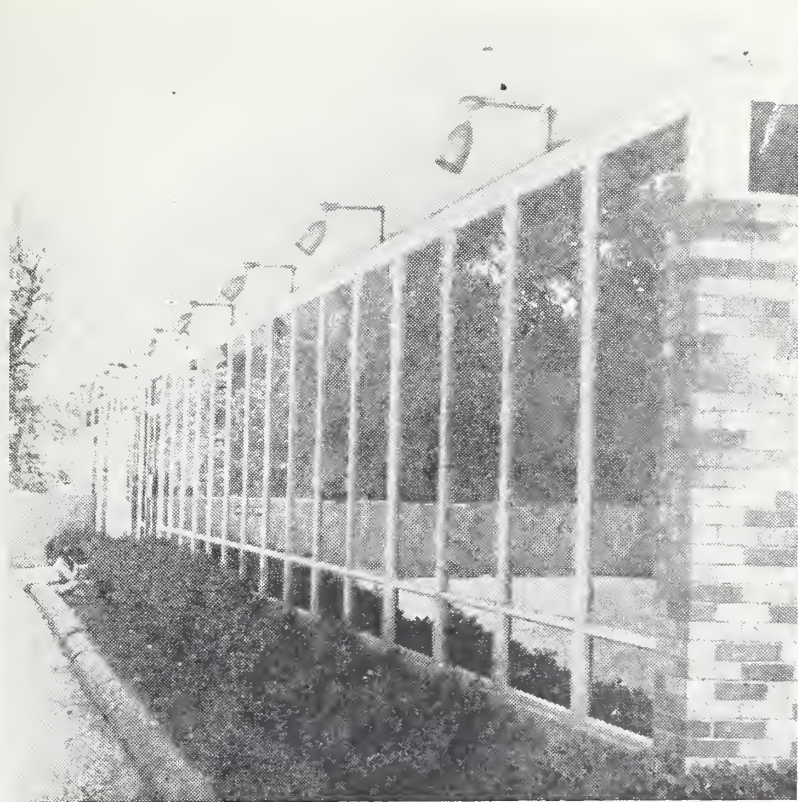
The contingent of Oklahoma representatives are expected to attend the 18th Annual Meeting of the American Association of Medical Assistants in Denver, Colorado, September 24th-29th. Two top officials of the American Medical Association will head an impressive list of physicians on the program.

AAMA, an organization representing the men and women employed in physician's offices, will devote its annual meeting to discussions of such topics as Professional Standards Review Organizations, Office Safety, Patient Care, and will conduct special workshops in obstetrics and gynecology, pediatrics and pathology.

In addition to its annual meeting, AAMA conducts numerous meetings throughout the year for its 15,500 members. Its programs of continuing education include an annual certification examination offered in more than seventy centers throughout the country. The AAMA also collaborates with the American Medical Association in evaluating educational programs for medical assistants in order to establish and maintain curriculum standards. Currently there are seventy-five accredited programs.

Hillard Denyer, MD, a Past-President of the OSMA, currently serves as one of AAMA's National MD advisors. □





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## DEATHS

J. B. ESKRIDGE, JR., MD  
1896-1974

A prominent Oklahoma City obstetrician and gynecologist, J. B. Eskridge, Jr., MD, died following a brief illness on August 24th, 1974. He was the father of J. B. Eskridge, III, MD, another Oklahoma City obstetrician and gynecologist.

Born in La Vergne, Tennessee, Doctor Eskridge was graduated from the University of Oklahoma College of Medicine in 1921, where he later became Chairman of the Department of Obstetrics and Gynecology.

He was a member of the Oklahoma City Obstetrical and Gynecological Society, the Central Association of Obstetricians and Gynecologists, the Oklahoma City Academy of Medicine and the International College of Surgeons.

In 1971, Doctor Eskridge was honored twice by the Oklahoma State Medical Association. He was presented membership in the Fifty Year Club in recognition of half a century of dedicated service to humanity and he also became a Life Member of the association for his outstanding aid to his patients and profession.

JAMES C. BROGDEN, MD  
1888-1974

A retired Tulsa physician, James C. Brogden, MD, died in Tulsa August 5th, 1974. Born in Wagoner, South Carolina, Doctor Brogden received his medical degree from the University of Maryland School of Medicine and College of Physicians and Surgeons in 1914. He had practiced in Tulsa for over 46 years before retiring in 1967. He had been active in both civic and medical affairs having served as President of the Tulsa County Medical Society. The OSMA had awarded Doctor Brogden a Life Membership for his years of dedicated service.

NOBLE F. WYNN, MD  
1918-1974

An Edmond general practitioner, Noble F. Wynn, MD, died at his home on August 12th, 1974. Born in Hollis, Oklahoma on March 10th, 1918, Doctor Wynn was graduated from the University of Oklahoma College of Medicine in 1942, where he later became an instructor in pharmacology. Following graduation, Doctor Wynn served a two-year internship at Wesley Hospital in Oklahoma City before entering practice in Edmond.

THOMAS J. McGRATH, MD  
1902-1974

A Sayre physician since 1927, Thomas J. McGrath, MD, died July 28th, 1974. Born in Delhi, Oklahoma, Doctor McGrath was a lifelong resident of Beckham County. He received his medical degree from the University of Oklahoma College of Medicine in 1927 and following his internship, established his practice in Sayre. He was a Past-President of the Beckham County Medical Society.

E. W. KING, MD  
1878-1974

E. W. King, MD, 95-year old Bristow doctor died July 26th, 1974. He had practiced in Bristow since 1905 and saw patients until a few weeks before his death.

Born in Charleston, Illinois, Doctor King was graduated from the University of Louisville School of Medicine in 1905. He had been active in both civic and medical circles and had served as mayor of Bristow at one time. The OSMA awarded him a Fifty-Year Club membership in 1955, recognizing his long devoted years of service to humanity. □



## Tulsa Medical College Accepts Sixteen Third-Year Students

Sixteen third-year medical students have begun medical training programs at the University of Oklahoma Tulsa Medical College.

Designed for students who have completed their first two years of medical school, the Tulsa Medical College provides intern and resident training at four Tulsa Hospitals. The program is funded by the Tulsa Medical Foundation, a non-profit organization composed of Tulsa physicians and hospitals.

Dean of the new Tulsa Medical College, Doctor Martin FitzPatrick, said the Tulsa facilities will aid in developing the OU Health Sciences Center Residency Program by giving students more experience and providing more opportunity for students to practice in many fields.

St. Francis, Hillcrest, Children's Medical Center and St. John's Hospital will be used as training centers for the Tulsa students. Emphasis will be placed on the Department of Family Practice to increase the "basic science education" capacity of the OU Health Sciences Center. Students will also participate in the departments of medicine, surgery, pediatrics, obstetrics-gynecology and psychiatry.

"I think the emphasis we give to these programs will aid in getting more family practitioners out to the people," said Doctor FitzPatrick. Because of the Tulsa Medical College, "we can target our programs a little bit in terms of what kind of medicine students want to practice," he said.

Of the sixteen medical students in Tulsa, only two of them are from outside the State of Oklahoma. □

## Pharmacists Ask Physician Cooperation In Prescribing

Oklahoma's pharmacists met for their annual meeting in June and passed a number of resolutions requesting physician assistance in prescribing.

The resolutions, adopted by the Oklahoma Pharmaceutical Association, were among 24 resolutions dealing with all aspects of the practice of pharmacy.

Cooperation in the area of prescriptions to be refilled was requested. One resolution stated that "many physicians are still not specifying whether or not a prescription should be refilled

..." This situation results in the pharmacist having to call the physician to make the determination. The pharmaceutical association asks all physicians to specify on the prescription form whether or not the prescription is refillable upon request.

Another vexing problem faced by the pharmacist is the presentation of a prescription on a hospital prescription blank without the imprinted name of the physician. The resolution states, "It is impossible to ascertain whom to contact in the event of a question pertaining to the prescription order."

The pharmaceutical association urges all prescribers to include their Name and B N DD number on prescription orders in a readable fashion.

The pharmacists reaffirmed their opposition to any change in the ant substitution laws of Oklahoma. The resolution stated, "the membership decrees that the repeal of our ant substitution law is not in the best interest of the public health, and . . . the position to repeal such laws increases the dissension as well as widening the gulf among pharmacists and physicians . . ." The resolution ends by urging that all members of the pharmaceutical association continue opposition to repeal or alteration of the current law. □

## Physicians Must Supply Injured Workmen With Report

Many physicians have been unaware of a change made in Oklahoma's Workmen's Compensation Law about a year ago. The law now provides that the attending physician must supply a full report to the employer and the injured employee within seven days after examination.

The change in the Workmen's Compensation Law was pointed up during the OSMA-Oklahoma Bar Association's Medical-Legal Institute at Fountainhead Lodge. In 1973 the law was amended to provide, "The attending physician shall supply the injured employee and the employer with a full examining report of injuries found at the time of examination and proposed treatment. This report should be supplied within seven days after the examination; also, at the conclusion of the treatment the attending physician shall supply a full report of his treatment to the employer of the injured employee."



At the same time this particular addition was made to the law, it was also amended to provide that the injured employee could select a physician of his own choice to render the necessary treatment. This was the controversial part of the law which allowed the injured employee to select chiropractors for his care.

Most physicians are unaware of the change in the law regarding the reports. In the past it was only necessary for the physician to report to the employer. However, the law now states specifically that the "attending physician shall supply" the report to the injured employee. □

### **Test Developed By OU Professor To Be Used By FDA**

A method for detecting glucose in blood developed by Doctor Kurt Dubowski, a Professor at the University of Oklahoma Health Sciences Center, will be used in the government's first effort to evaluate commercially available reagents and materials used for the same purpose.

The use of Doctor Dubowsky's test was announced in July by the Federal Food and Drug Administration. Doctor Dubowsky, a Professor of Clinical Chemistry and Toxicology, said that glucose determination in blood is the most commonly performed clinical chemical laboratory procedure and often a most crucial test in diagnosing diseases such as meningitis and diabetes.

"For example, changes in spinal fluid glucose content are crucial in diagnosing meningitis," Doctor Dubowski said. "If a child is brought into an emergency room with symptoms of meningitis, he may need an accurate and speedy glucose test to confirm the diagnosis and possibly save his life."

The need for a standard of accuracy in glucose test is emphasized by the fact that there are currently hundreds of testing methods and dozens of commercial "kits" available in the United States.

Doctor Dubowski's test would be used as a "yardstick" to measure the accuracy of results obtained by other methods. Laboratories that use his method get correct results most often, according to Federal Center for Disease Control Tests. Consequently Doctor Dubowski's method was chosen as the Standard of Accu-

racy by an FDA panel of experts.

Although Doctor Dubowski developed the basic method 14 years ago, it is now being used in the government's first effort to evaluate commercially available diagnostic agents. □

### **O'Donahue To Head New Sports Medicine Division**

A new Division of Sports Medicine has been added to the Department of Orthopedic Surgery at the University of Oklahoma College of Medicine. The creation of the new division and the announcement of the new division head was made by Joseph A. Kopta, MD, professor and chairman of the Department of Orthopedic Surgery and Fractures.

Don H. O'Donahue, MD, was named to be the first head of the newly created division of sports medicine. He was professor and chairman of the Department of Orthopedic Surgery at OU from 1948 until 1973, when he assumed an emeritus title.

The doctor is renowned for his contributions to the field of sports medicine and include over 78 publications and a book "Treatment of Injuries to Athletes" which is considered a primer to the field.

The new division head is a Past-President of the American Orthopedic Association and Past Vice-President of the American Academy of Orthopedic Surgeons. He is a founding member and a first President of the American Orthopedic Society for Sports Medicine. □

### **Cooper Recognized As Outstanding Team Physician In America**

An Oklahoma physician, Donald L. Cooper, MD, has been designated as the "outstanding team physician in America" by the National Athletic Trainers Association.

The announcement of the award and presentation of a special trophy were made in Kansas City, Missouri, at the NATA's 25th anniversary meeting in June. The award is given for outstanding contributions in sports medicine.

Doctor Cooper is director of the University Hospital and Clinic at Oklahoma State University in Stillwater. His award includes a beautifully sculptured trophy and a \$1,500 grant for either research or education in athle-



tic health care. The doctor contributed the grant to the OSU Development Foundation for use by the athletic department in the designated fields.

Cooper is a member of the AMA's Committee on Medical Aspects of Sports and was an official United States Team physician at the Olympic Games in Mexico City in 1968. Since 1969 he has been medical consultant for NCAA Football Rules Committee and has served for the past six years as Chairman of the NCAA's Committee on Competitive Safeguards and Medical Aspects of Sports.

In 1972 and '73 he testified before congress on the medical aspects of sports. Since 1970 he has served on the NCAA Committee on Drug Education.

In 1967 Doctor Cooper represented the United States as the US Chairman for the American-Soviet Conference on Student Health in Moscow. He is a Past-President of the American College Health Association and Past-Chairman of the Athletic Medicine Section of ACHA. □

## Dean Bird Accepts Position At National Library of Medicine

After 22 years of service to Oklahomans Dean Robert M. Bird, MD, is leaving the University of Oklahoma College of Medicine to assume a new position as Director for Biomedical Communications at the National Library of Medicine.

In the letter to Jack L. Richardson, MD, OSMA President, Doctor Bird said, "This is just a brief and more or less official 'thank you note' to you for transmittal to the staff of the association and for the many friends who are members. Leaving Oklahoma after 22 years is not easy. The University of Oklahoma College of Medicine and the medical profession of the state have been bountifully good to me. Hopefully, I have reciprocated in fair measure. My confidence in the college and in our profession continues to be firm."

Doctor Bird went on to say, "The office of the Dean is in the capable hands of Doctor Tom Lynn. Please give him the help and understanding which was always my good fortune to receive."

The Dean's letter ended by saying, "In good time, I will be putting down new roots in organized medicine in Maryland. Then I will call

on you and others to support my application and trust that you can stretch the truth in my favor! Until then, to you and to the entire association, thanks, cheers and good luck."

Doctor Bird's new address will be: Director, Lister Hill National Center for Biomedical Communications, National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20014. □

## Miscellaneous Advertisements

**EMERGENCY ROOM PHYSICIAN WANTED.** Opening on the staff of 12 multi-specialty doctors to work in E.R. of 74-bed hospital, also work with industrial department doing pre-employment physicals and industrial injuries. Write Key M, The Journal, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118.

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## Summer Report of the President

The 1974-75 auxiliary year has begun with continuing programs and new projects underway. The national convention was held in Chicago, June 23rd-27th, with Mrs. John W. Williams, Mrs. William B. Renfrow, Mrs. Joe Crosthwait, Mrs. Scott Hendren and Mrs. Alfred T. Baker attending each session as delegates. The alternates were Mrs. Ed Calhoon, Mrs. Orange Welborn, Mrs. Adolph Vammen and Mrs. Jack Richardson.

Keynote speaker at the opening session was Joyce Brothers, PhD, whose subject was "Family Life—Pros & Cons." She stated that doubts the family would survive have been expressed for 2,000 years. Despite attempts of governments and religions to supplant it, the family has survived and remains today the basic unit in primitive cultures as well as advanced countries.

Doctor Virginia Agpar, National Foundation — March of Dimes, spoke on "Genetic Counseling" and expressed the belief that birth defects could be sharply reduced if young people considering marriage would determine through genetic counseling if their genes as well as their personalities were compatible — and heeded the counseling.

The annual luncheon honoring AMA officers, trustees and wives, was of special interest

to Oklahomans. In addition to the presentation of a record breaking contribution by the AMA Woman's Auxiliary to the AMA-Education and Research Foundation (\$1,207,478), Oklahoma

received an Award of Merit for the state contribution of \$15.79 per capita. A special award was received by Mrs. Scott Hendren, AMA-ERF Chairman for 1973-74, in behalf of the outstanding work done by the Atoka-Bryan-Coal Counties Auxiliary. They received an award for the largest contribution, \$206.50, per capita for all counties in the Woman's Auxiliary to the AMA.

Mrs. Howard Liljestrand was installed as the National President. In her inaugural address "Reach for the Stars," Mrs. Liljestrand pointed out the distinct qualities of members of the auxiliary. She urged increased membership, county auxiliaries identified as service groups, the promotion of health education in the schools to produce more fit adults and alertness to community needs.

The summer board meeting was held August 5th at the OSMA building with 29 members hearing committee plans for the year. Mrs. E. Cotter Murray presented ideas for AMA-ERF fund raising in the state.

I am looking forward to visiting with many of you at district meetings this fall. The State Fall Conference will be held on November 11th at the OSMA building in Oklahoma City.  
*Charlene Williams* □



**OSMA's 1975 medical directory** is in the works. All Oklahoma medical doctors were sent Directory Survey Forms during the latter part of August. The information compiled from the survey forms will be used by the association to prepare the 1975 medical directory. All physicians in the state will receive a free copy of the directory when it is published.

**National Health Insurance** is coming, but it may be far from a blessing. According to a report by the Rand Corporation, published in the *New England Journal of Medicine*, NHI would result in physicians' and dentists' offices being swamped, costs would be in the billions of dollars and there would be little effect on the life expectancy or general well being of Americans. The report, published in the June 13th issue of NEJM, is based on two prototypical national health insurance plans, one providing full coverage and one containing a 25% coinsurance provision. Under the full coverage plan, it is estimated the demand for physicians services would be increased 75% and the cost for inpatients and ambulatory services would be increased by eight to sixteen billion dollars. Under the co-insurance plan, the demand for physician services would rise 30% and the cost would rise by three billion dollars. The report notes that estimates are conservative, are not corrected for general inflation, and are based on the assumption that supply would equal demand.

**Licensed physician increase** in 1973 established a record. 16,689 licensed physicians were added to the US medical profession. This was a 15% increase over the number reported in 1972. Of the new group, 7,419, or almost one-half, were graduates of foreign medical schools. As of the last day of 1973 there were 366,379 physicians in the United States.

**Ethical and legal questions** concerning physicians participation and weight reduction "clinic" that advertise the use of human chorionic gonadatropin injections are being raised. The widely advertised "fat clinics" which use HGC, a substance made from the urine of pregnant women, are offering physicians large sums of money to affiliate; with them. The AMA and FDA have both said the HGC has not been proven useful in the treatment of obesity. In two states, California and Michigan, either the state medical society or the attorney general has warned physicians of the ethical questions involved in affiliating with such a clinic.

**Some conclusions on acupuncture** were reached by the AMA's delegation to China after its recent visit. The delegation said that acupuncture and analgesia merits controlled experimental study and that clinical studies of its applicability might best be carried out to cooperative ventures between accomplished Chinese practitioners and licensed American physicians, dentists, and research scientists. Acupuncture therapy should be regarded as the practice of medicine in an experimental phase, permissible only in qualified investigational settings, the delegation said. It added that every effort should be made to guard against the conversion of acupuncture into a new kind of quackery in the western world.

**Now here's a switch**, Ralph Nader has told the Ways and Means Committee of the United States Congress not to pass National Health Insurance this year. However, he couldn't pass up an opportunity to take a slap at the medical profession when he said, "It is debatable that the aggregate health of this country is being advanced by the presence of the medical profession." □



## A Biomedical "Watergate"\*

In the spring of this year, the medical-scientific community suffered its own "Watergate" scandal, with morally untenable misdeeds by one individual, attempted cover-up, with the blame attributed only to the culprit at hand and the final denouement with its broader implications.

While the general press and the medical news media, notably *Medical World News*, have broadly covered the affair, the medical-scientific press, with the exception of *Science*, have almost ignored it (see Footnote). There are probably many scientists and physicians who are unfamiliar with the events, although they allow some important conclusions of general significance.

The case involves a 35-year-old well established investigator, Dr. Summerlin, who was head of the immunobiological laboratory and clinical dermatologist at New York's world renowned Memorial Sloan-Kettering Cancer Center. Summerlin and his mentor, the famous immunologist Dr. Robert A. Good, had conducted research at the University of Minnesota in Minneapolis which indicated that skin, when maintained for several weeks in tissue culture, loses its normal ability to provoke an immune response or rejection phenomenon when transplanted to an unrelated host. This of course, if proved valid, was sensational and of the greatest practical importance in transplantation procedures such as are practiced in burns. After Good's transfer to New York as President of the Sloan-Kettering Institute for

Cancer Research and the subsequent appointment of Summerlin to a key research position at the same institute, the latter broadened his research on mice and reported in 1973 that the skin of inbred mice when maintained in culture for up to 10 days could be transplanted to genetically incompatible animals without being rejected. He also stated that whole human rabbit corneas as well as adrenal glands, when kept in culture, appeared to lose their antigenicity. Dr. Good, who was present at several scientific meetings where Summerlin presented his findings, backed the work with vigor and enthusiasm. But a number of immunologists were skeptical, particularly when several investigators, repeating Summerlin's experiments, were unable to duplicate his results, among them the world famous immunologist and Nobel Prize winner, Sir Peter Medawar, who finally dropped this work altogether in frustration and disappointment. Summerlin's findings became less and less credible, particularly when other scientists at Sloan-Kettering were unable to reproduce his work and two New York ophthalmologists, who originally collaborated with Summerlin and who had undertaken additional corneal transplants on rabbits, could not confirm Summerlin's postulated acceptability of the transplants. Although Good continued to back Summerlin in public he must have had his doubts, since he requested other scientists at the Institute to repeat Summerlin's work. *Science* asked the interesting question: "Why was there, what appears to be a cover-up?"

The final denouement came on the 26th of March of this year when Summerlin in preparing a series of mice for demonstration to Dr. Good, painted the skin of two white mice who had received transplants of cultured skin from

\*This editorial was written before the extensive report on the Sloan-Kettering affair appeared in the "Medical News" section of the J.A.M.A. The two comments barely overlap, but supplement each other. While the J.A.M.A. narrative concerns itself essentially with the detailed curriculum of the personalities involved and with the elaboration of their actions climaxing in the falsification of data, this editorial attempts to look behind the events, to point out the causes of these fateful happenings and to suggest means for avoiding such occurrences.



black mice, with his black felt tip pencil. When this falsification leaked out at the Institute and was brought to the attention of Dr. Good, Summerlin was immediately suspended. After the public press broke the story (without any particular cooperation from the Institute), a review committee was appointed to investigate the affair with the result that Summerlin's relationship with the Center was terminated, granting him a medical leave of up to one year with full pay. It was also revealed that Summerlin had suffered from an emotional disturbance stemming from pressure and overwork and had consulted a psychiatrist. A committee of experts found in Summerlin and Good's work, going as far back as four years, a "lack of properly organized and analyzable data." It blamed Good for not properly supervising Summerlin's research and for undue publicity surrounding his claims.

Parenthetically it might be remarked that some scientific findings could possibly be salvageable, particularly the hypothesis that tissue culturing might be a process of neutralizing immune reactions.

What are the lessons learned from this affair? First of all we have to eliminate from our mind, to quote Lawrence Kubie, "the idyllic picture of the innocent child-like scientist who lives a life of simple, secure, peaceful dignified contemplation." Scientists nowadays are deeply involved in practical problems of everyday life, particularly those of creating a public image and establishing public relations in order to compete for general recognition and monetary support. This fight for financial backing has become quite fierce, particularly after the cut-back in federal research funds. More than ever the scientist has not only an emotional, but also a very practical stake in the successful outcome of his work. "Breakthroughs" are rare, but are amply rewarded with recognition, fame and remunerative compensations. Out-and-out frauds are uncommon, although they occur more often than one might think. Usually the deceptions are more subtle and frequently based on uncon-

scious behavior such as suppression of negative or contrary data. The pressure on the scientist from his institution, which controls his promotion, and the fund-granting agencies is never ending, leading to a "publish or perish" atmosphere. In order to preserve or enhance his public image or win the race for priority, the scientist may telescope his research and present it to the scientific public prematurely with the dangers of incompleteness and short-cuts. The same piece of research may proliferate into a number of published manuscripts and addresses given before various scientific audiences.

What can be done to avoid such excesses? Learning from the case reported, no scientist should be his own, sole critic. Preferably a group of associates rather than a single investigator should, if indicated, conduct the research. Double-blind studies, whenever possible, are of course a great help in suppressing individual bias. Before publication the author or authors should present the material to their peers at seminars and other intramural meetings with free and uninhibited discussion, and their peers as well as their superiors should critically review the execution and evaluation of experiments. But first and foremost there should be a sharp separation in the leadership of a research institution between those that initiate or supervise the research of the participating investigators and those that are responsible for the fiscal problems of the institution, including public relations. In our case there was a joining of the two functions, in which the president of the institution, an outstanding scientist and researcher, felt that he had to push his investigators in order to produce speedy results. He rather flamboyantly publicized these in order to obtain funds. He was eminently successful in the latter attempt by raising government grants and contracts from seven million dollars in 1972 to 20 million dollars in fiscal 1975. However, he failed to offer a critical, but humane and patient leadership, conducive to significant, productive research. *Ernest Lachman, MD*





Mr. Caspar Weinberger of HEW has come up with some "brilliant" statistics that would hardly do justice to a good 6th grade school child. He has told Congress and the news media and the public in general that doctors' fees are going up at the rate of al-

most 20% a year. But guess how he arrives at this figure. He states that in the three months following the lifting of the price freeze doctors' fees went up 4.7%, then he converted this to an annual statistic by multiplying by four and finally arrives at the percentage of 19.1! Now this is indeed a very unique way of figuring an annual statistic and is fallacious on the very face of it. His computation was conveniently made immediately after medical fees had been frozen for the previous two and one-half years. Weinberger is smart enough to know that this is a bad statistic and can only be self-serving to him and his philosophy. Yet he spews this to all and sundry.

Incidentally, have you seen or heard the fallacy challenged or refuted publicly by the AMA? Where are our national spokesmen? It has been said that the AMA has one of the most expensive lobbies in Washington. If this be so, then much is being spent on very little. It strikes me that we are not getting much for our dues. It seems efforts in our behalf are made too little and too late; compromise, concurrence and compliance, come all too readily. We need strong, effective, active and mature representation in Washington, closely supervised and monitored by an alert, judicious and informed staff at the AMA. I have yet to be convinced we have had this. The various state associations need to be advised by the AMA what bills are coming up well in advance of their presentation on the floor of Congress and well in advance of their consideration in committee. And, importantly, the impact of these measures should be pointed out to us by the considerable AMA staff. Too often, constituent associations have to explain the significance to the AMA. We should be provided consultation from the AMA political staff in preparation for timely nationwide intervention with our respective legislators.

We keep hearing about the cost of medical care being a "crisis," but I have yet to hear a single patient call the current medical condi-

## OSMA JOURNAL / *president's page*

tions by that name — such allegations only being made by the politicians and bureaucrats eager to process a \$100 billion department.

As a matter of fact, a good case can be made that there are many "crises" in this country more serious than the medical situation and it can further be proven, without such mathematics as Weinberger's, that the cost of medical care, proportionate to other costs, has inflated considerably less.

Of course medical care is expensive in these inflationary times. What isn't? If medical care is inefficient and costly now, what can be expected to happen with the intervention of government is rather horrible to contemplate. When PSRO fails to control the spiralling cost of Medicare and Medicaid — and it will not — the blame will be placed on the medical profession and its fee-for-service system, this then contributing to the argument that NHI is necessary. Just reflect on what has happened to the costs of Medicare and Medicaid. They were estimated to cost \$4 billion and now cost \$20 billion, in spite of all kinds of co-insurance, exclusions, deductibles, limitations, delayed payments to doctors and hospitals, and supervision by utilization committees.

What has Congress done to anticipate and cure our other "crises?" They were less than gungho about getting the oil in Alaska to offset the Arabian oil problem; or to control crime in our streets; or to handle the public housing deficiency; or to get atomic power developed for commercial use — and ad infinitum.

Yes, doctors' fees may seem high, but consider that two boxers are meeting for a cool \$5 million each for one fight; that the Beatles came to the U.S. and made \$20 million; that \$1 million a month can be made by a Las Vegas entertainer; that the "Evil One" made a fouled-up rocket jump dragging a "bit early" parachute and cleared \$5 million. Is there any public outcry that these are outrageous?

*J. L. Richardson, M.D.*



# A Comparative Study of Amphetamine, Ephedrine-Atropine Mixture, Placebo and Behavioral Conditioning in the Treatment of Nocturnal Enuresis

LOGAN WRIGHT, PhD  
SHELLEY C. CRAIG, MA

*Twenty-one enuretic children between four and ten years of age were randomly assigned to receive either pad and bell conditioning or medication treatment. The conditioning group maintained a significant decrease in wettings per week after four weeks. The drug group showed an initial decrease in wettings which could not be maintained. This change was interpreted as primarily placebo effect.*

Several researchers,<sup>1-7</sup> have reported favorable results with a variety of treatments for nocturnal enuresis in children. Various antidepressants and stimulants have been used with varying degrees of success. Poussaint, *et al*<sup>1</sup> theorized that drugs may work in one of four ways: (1) as an influence on mood (antidepressant); (2) as an anticholinergic agent which relaxes the detrusor muscle and contracts the bladder's sphincter muscles; (3) as an analeptic

agent which lightens a child's sleep so that he is more easily aroused by the stimulus of a full bladder; (4) by any combination of these methods. Kunin *et al*<sup>2</sup>, reported imipramine (Tofranil) to be effective and more so than ephedrine in two groups of enuretic children between five and fifteen years of age; one with no organic disease and the other with definite physical defects. Poussaint *et al*<sup>1</sup> investigated the effects of amitriptyline (Elavil) with 50 outpatient enuretic children, aged five to fifteen years. Ten percent of these subjects became completely dry and remained so when the drug was withdrawn, and 62% had various degrees of improvement with a small percentage of relapses. Dubow<sup>3</sup> treated two sets of subjects with yet another stimulant, an ephedrine-atropine mixture. The first group, which was followed for three months, was divided into a placebo control group and the drug treatment group. The second set of subjects were all treated with the ephedrine-atropine mixture and followed for six months. Dubow defined moderate improvement as a decrease in wetting frequency to half, or less, of initial wetting frequency. Thirty-two percent of the placebo subjects, and 56% of the three-month group achieved moderate to excellent improvement, but with a high relapse rate. In a double blind comparison study of ephedrine and triclofos, anonymously submitted to *Practitioner*<sup>8</sup> no significant difference

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was found between the two drugs in treating nocturnal enuresis.

The pad and bell conditioning device, based on the psychological theories of Pavlov, Skinner, and others, is a distinctly different method for treating enuresis. This approach has generally proven quite successful. The program involves conditioning or "sensitizing" a child to awaken in order to prevent his sphincter from relaxing and thereby permitting urination. The "sensitizing" is accomplished by the pad and bell device which is placed in the child's bed. When the child urinates, a loud bell rings and a bright light comes on, awakening the child. Using this method, Seiger<sup>5</sup> reported that 88.8% of his 106 patients (aged 2½ to 29 years) have been dry for periods of two months to many years; 7.5% were considerably improved and only 3.7% were defined as failures. Schwartz<sup>6</sup> treated 26 patients (aged 5 to 22 years) by means of a pad and bell conditioning program. Of 14 subjects who have finished the program, 13 became completely dry, based on a criterion of 14 consecutive dry nights, while the other subject was variable, but usually dry 90% of the time. However, three children relapsed and were readmitted for treatment. Jones<sup>4</sup> in a review of 12 studies in which 1446 enuretics were treated with pad and bell conditioning, reported 76% of all patients were rated as cures and 14% as failures (criteria for success differed with each study).

Since both medication and behavioral conditioning had proven effective in treating enuresis, McConaghy<sup>7</sup> in 1969 conducted a

comparative study, the only such study reported prior to ours. He studied the efficacy of stimulants (imipramine and amphetamine), pad and bell conditioning, random awakening, and placebos. In this investigation the pad and bell produced the best response both immediately and at a one-year follow-up. Imipramine was significantly more effective than amphetamine, and amphetamine produced a slightly better response than the placebo, though this difference was not significant. McConaghy concluded that conditioning is significantly better than the drug, random awakening, or placebo treatments. The purpose of our study was to perform something of a replication of McConaghy's study by comparing the effectiveness of two stimulants (Enuretral and amphetamine), pad and bell conditioning, and a placebo in correcting nocturnal awareness. It was predicted that the pad and bell device would be the most effective and consistent treatment.

#### METHOD

Twenty-three enuretic children between four and ten years of age were admitted to the study by a private physician. Medical examination precluded organic or infectious cause in each case. Subjects were randomly assigned (on a 50-50 basis) to either the pad and bell or medication (including placebo) groups. Within the medication group, subjects were also randomly assigned to each of the three subgroups. Of the 23 subjects, three were assigned to the amphetamine sulfate treatment group (T1), five to the placebo group (T2), five to the atropine-ephedrine, or Enuretrol group (T3), and ten to the pad and bell conditioning group. Amphetamine sulfate (T1) is a mild CNS stimulant to prevent deeper levels of sleep and was administered in a dose of 2.5 mg (one-half tablet of Bensedrine) at bedtime during the five-week treatment period. The ephedrine sulfate and atropine sulfate mixture (T3) is an autonomic stimulant which acts as a sphincter control to hinder urination. A 7.5 mg dose of ephedrine sulfate and a 1.15 mg dose of atropine sulfate (in a single tablet of Enuretrol) was administered twice daily, once in the morning, and once at bedtime. Treatment group T2 received a placebo twice daily. Each medication was coded so that the attending physician and the parents were not aware of patients' treatments. Parents kept a record of the child's enuresis (number of episodes per night and size of spot) for four

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*Shelley C. Craig, MA, received her degree from George Peabody College in 1973. She is a member of the Society for Pediatric Psychology.*



weeks before treatment, for five weeks on the assigned treatment program, and for four post-treatment weeks. Two subjects had to be dropped from the placebo group (T2) because parents refused to comply with the study's protocol.

#### APPARATUS

The pad and bell device consisted of two metal pads separated by a piece of paper toweling. The toweling prevented completion of the electrical communication between the two metal pads. The top pad was perforated to allow urine to soak through and complete the electrical circuit, which activated a buzzer and light. This would then awaken the subject enough for him to stop urinating.

#### RESULTS

The mean number of wettings per week during the five-week treatment period for the pad

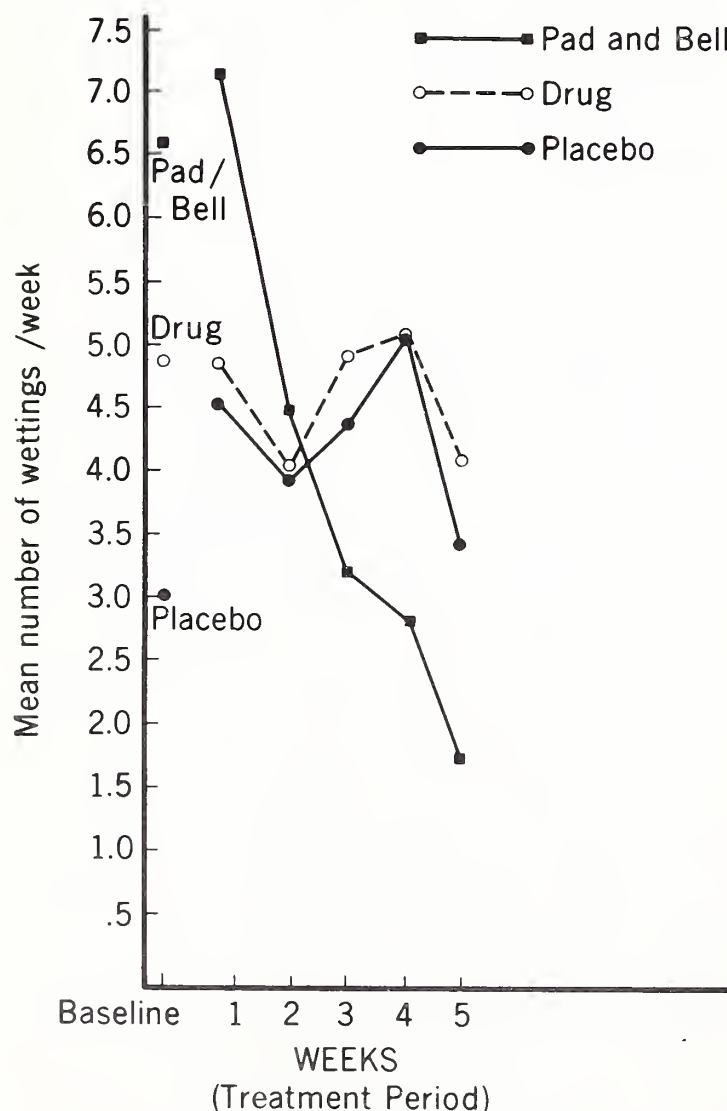


Fig 1

Table I: Matched Pairs Test of Baseline Compared With Weeks of Treatment for Pad and Bell and Drug Therapy Group

Baseline compared with respective weeks of treatment	Pad and Bell Group	Combined Drug Groups
Baseline vs Week 1	.610	.469
Baseline vs Week 2	1.348	2.183
Baseline vs Week 3	1.849	2.376*
Baseline vs Week 4	2.618*	-.143
Baseline vs Week 5	2.836*	1.174

\*Equals  $p < .05$

Note: No groups were significant at .01 level

and bell, placebo, and drug therapy groups (drug subjects were combined into one group) are shown in Fig. 1. The results for the pad and bell and combined drug groups were submitted to a matched pairs test. Table 1 shows the comparison between the baseline and five weeks of treatment for the pad and bell and drug therapy groups.

Significant differences between baseline and number of instances of enuresis for both week four and week five were obtained for the pad and bell group ( $t=2.618$  and  $2.836$  respectively,  $df=9$ ,  $p < .05$ ). However, the drug group obtained a significant difference from baseline during only one week (week three) ( $t=2.376$ ,  $df=7$ ,  $p < .05$ ). None of the tests for the placebo group were significant. However, this group reacted very similarly to the drug group, with initial decrease in mean number of wettings but inability to maintain this gain.

#### DISCUSSION

This modified replication of McConaghy's 1969 study supports his finding that a pad and bell conditioning device produces a significantly better response among nocturnal enuretics than do drugs or placebo.

In this case, the pad and bell device was more effective than amphetamine, ephedrine, or placebo. Control over nocturnal enuresis is gained somewhat slower than with drugs, but the change seemed to be more permanent. Neither drug was able to effect a lasting decrease in mean number of wettings per week. Thus, improvement in the drug group appeared to result from a placebo effect, which produced an initial surge of improvement but no lasting benefit.

#### SUMMARY

Twenty-one enuretic children between four



and ten years of age were randomly assigned to receive either pad and bell conditioning or medication treatment. The conditioning group maintained a significant decrease in wettings per week after four weeks. The drug group showed an initial decrease in wettings which could *not* be maintained. This change was interpreted as primarily placebo effect. □

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Reprint request should be directed to Logan Wright, PhD, Children's Memorial Hospital, P.O. Box 26901, Oklahoma City, Oklahoma 73190.

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# "FLUID and ELECTROLYTE PROBLEMS in the SURGICAL SPECIALTIES"

**November 2nd, 1974**

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**Lake Eufaula, Checotah, Oklahoma**

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## What Do You Want To Be When You Grow Up?

SOLOMON PAPPER, MD

*To grow up as a physician requires the acquisition of skill, technical capability, experience and growth as a human being. To grow as a human being is to recognize and strive for the realization of life's human purposes (concern for justice, compassion and scholarship-truth) while recognizing the reality and strength of the dehumanizing process.*

The major problems in the maturation of medical education today can best be understood in the historical perspective based on an analytical assessment of the various direct and indirect forces that have converged to bring us to where we are at this point in time. We can then proceed with incisive focus to open a meaningful dialogue concerning the essential communication and institutional interfaces that comprise the transactional biogenetic influences of the present era. On these substantive building blocks and conduits we can examine where our real challenges are, where our thrusts should be, and with what momentum

we can discharge our societal responsibilities. Are they in the arena of human interactions or in the operational exchanges of outreach programs and consumer health advocacy or perhaps in the difficult and compelling zones of a systems analysis approach? The innate complexities of the core issues offer the promise of opportunity on the one hand as well as the potential for fulfillment failure on the other. The pitfall of such involvement is an excessively simplistic approach to multifactorial, over-determined conceptualizations.

If any of you understood what I just said you have a serious problem. This is just the sort of garbage that has come to litter our lives in general and clutter medicine and medical education as well. I believe it not only reflects and contributes to murky thinking, but even more importantly represents the triumph of technique over purpose that is so central in our *current* dehumanization scene. Today I shall consider with you in personal terms the human subject that has concerned me for some time — What do I want to be when I grow up? I *shall* deal with purposes.

When I was a child growing up in Brooklyn, New York, my answer to the question "What do you want to be when you grow up?" was a strong, compelling one. I wanted to be second baseman with the Brooklyn Dodgers. The dream remained unfulfilled not only because Jackie Robinson was available at the same time but also because, by any standards, I was not

From the Alpha Omega Alpha address at the University of Oklahoma College of Medicine, March 14, 1974.



good enough. I failed, and as Vincent Lombardi, the American philosopher said, "Show me a good loser and I'll show you a loser." The question "What do you want to be when you grow up?" was and is a common one to ask children and always implies career choice. Therefore, success or failure in growing up is generally judged in career terms. I have two points of departure today: (1) I am older than a half century and have finally become convinced that I am not yet grown up. And hopefully I am still growing. Indeed if I stop now I will represent a case of arrested development. For purposes of supporting my own ego and perhaps from what I see around me in my peers and elders, I perceive that the end point of being fully grown up is seldom if ever attainable. And while I know now that I shall never get out of this life alive, I shall be forced to depart incompletely grown. (2) It seems to me that the specific details of career choice represent only a small fraction of what should be implied in the question and answer to "What do you want to be when you grow up?" My answer now to the question would be quite different; it would have little to do with details of career, except as a role, as a means to other goals. Growing up I now see as pursuing with dedication the totally human purposes of: (1) *concern for justice*, (2) *compassion*, and (3) *respect for scholarship*. The means of pursuing these purposes and the obstacles along the way are the major subject of this discourse.

However, so that I am not accused of totally ignoring career choice, let's dispose of it—but in fairly short order. Most of us are or will be physicians, so the major career choice is answered. But even that can be changed at this late date: witness novelist Somerset Maugham, composer Jules Stein, and the revolutionary Che Guevera. Now what about the "little career choices," *ie* what field of medicine should I be in, and what form should my field take: should I be an academician, a solo practitioner, group doctor?

As someone who started professional life with a flirtation with orthopedics and who was diverted by circumstances and still unknown considerations to become a general internist, I have some experience with uncertainty. For students today the anxiety state is augmented by the greater uncertainty of our times as well as by the pressure for earlier decisions. I want to emphasize only a few general points: (1) We are fortunate to have the problem because it reflects an existing freedom for the student in our

country that does not exist everywhere in the world, and may not even continue here; (2) all fields are exciting and interesting, depending on what we make of them; (3) there is no such thing as a listing of fields in order of importance. To the child with strabismus, the most important physicians are the primary doctor who identifies the problem and the ophthalmologist who corrects it. A physician can be of valuable service in any field. That is one of the joys of our profession. Since real contentment for the civilized person requires being valuable, we are so fortunate that our profession offers many paths to that end; (4) I suggest total honesty in seeking the answer to this question: How do I see myself living (including working) ten years hence? Think of your personality and that of your family. Be realistic with yourselves and seek advice where needed. In the atmosphere of any medical school the role models are interesting and raise the question of whether certain people choose certain fields, or are molded by the field, or both. One sees a kind of professional posturing that distresses some and amuses others. With the hope that my colleagues in *all* fields, including internal medicine, will be generous with me, here are a few exaggerated examples of how some may be viewed.

### THE CAST OF CHARACTERS

- 1. The Administration .....tact, talk and diplomacy
- 2. The Internist .....the cult of the high priest
- 3. The Surgeon .....my hand is forced
- 4. The Pediatrician .....perpetual youth
- 5. The Anesthesiologist .....we are also relevant

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*Since his graduation from the New York University College of Medicine, Solomon Papper, MD, has been certified by the American Board of Internal Medicine. He is presently Distinguished Professor at the University of Oklahoma Health Sciences Center and Distinguished Physician at the Veterans Administration Hospital. Among his medical affiliations are the Association of American Physicians, a Fellow of the American College of Physicians, membership in the American Society of Clinical Investigation and a founding member of the American Society of Nephrology.*



## Want To Be / PAPPER

6. The Basic Scientist .....  
.....I know something you  
.....don't know
7. The Psychiatrist .....  
.....I know something you  
.....don't know and you cannot learn

So without selling any field or form of practice, I urge you to see yourself honestly and with some sense of humor. I know you *can* find professional contentment. Having disposed of the career choice so quickly, let us pursue the other and more important aspects of growing up — in my terms, the pursuit of human purposes.

The growing-up process is individual and should be seen in individual terms. While none of us is 100% physician, medicine as a career is such a strong part of the fabric of our total lives. Consequently, from here on I shall consider with you specifically the physician growing up as a human being.

When we applied to medical school, so many of us said we chose medicine because it allowed us to combine science with an interest in people. While I do not regard it as a poor perspective, it has the earmarks of a patterned response guaranteed to gain acceptability from an admissions committee. The physician members of the committee probably gave a similar reason when they applied, and the basic science members of the committee surely approved. It was a comfortable situation adding to all the other systems to assure self-perpetuation and therefore, obviously, high quality. I don't know exactly why I or others came to choose medicine; surely the reasons are many and varied. But through the years I have become reasonably convinced that, for many, part of the explanation is a desire to be a hero. Heroism and hero-worship strike me as so very human, so much more visceral than the cool combination of a yearning for science with an interest in people. And medicine is and has always been identified with heroism. Thus, even in ancient times The Talmud states "He who saves one life is considered as if he had preserved the whole world." Let's look at our heroes, and let us explore briefly what happens to too many of us. This is our track record taken from Crenshaw.

### THE TRACK RECORD

1. One out of 40 physicians is a hard-drug addict.

2. The production equivalent of two medical schools is lost each year to drugs.

3. The production of four medical schools is lost to alcohol.

4. The equivalent of one medical school graduating class is lost each year to suicide (twice the national average).

Obviously these alarming figures include only a small part of the misery and anguish suffered less dramatically. Why have so many of us come to this degree of dehumanization?

What happened to us? Are we selected so badly? Did it have its onset in the educational process? Are the pressures so very great, even beyond human endurance? Are heroes out of style, and do we suffer accordingly? While I would not agree in its entirety perhaps there is at least some substance to the remark by Pauline Kael, prominent movie critic, "The good guy has disappeared simultaneously from our society and from our movies." Have we lost sight of what it's all about? I really think so. In any event, whether in medicine or not, we need to explore the dehumanization process.

### THE DEHUMANIZATION PROCESS

While medicine by its nature is a very human profession, it is exceedingly vulnerable to being dehumanized — as I believe the rest of our world is. This view is expressed in somewhat harsh terms by Kateb writing in *Social Research* in 1973, "The supreme irony is that you can, by conditioning, transform a human being into everything except a human being — a deadly blow to the concept of a person that will make it easier for people to do violence to each other." And, surprisingly, medicine even seems to have its own unique temptations to depart from its fundamental humanitarianism. The following are only some of the examples of dehumanization as they apply to us: (1) *The use of language* reflects some departure from human values and serves to perpetuate and teach devaluation, eg cases instead of patients, pathology instead of patients, vegetables, bums, crocks, and turkeys. While I regard these as obscene, I confess to feeling remorse for the otherwise fine physician or student who dehumanizes himself even for that transient moment he uses such terms — few would have done so before they reached medical school. (2) *the use of computers*. Computers can be wonderful helps, but they do not have the human endowment to feel, to bleed. (3) *The laboratory*



advances have been magnificent, and I do not care to return to my earlier years without them. But the laboratory is only an added dimension for evaluation; it cannot replace judgment or feeling, and from the patient's view the laboratory is no substitute for the application of the physician's hand. (4) *A tendency for non-humanistic approaches to problems.* How often, even in the medical school world, do we witness a preoccupation with rules, policies, rigid criteria for this and that as a digression from what are essentially personal and human issues? (5) *A greater concern with and reward for technique* rather than human purpose. An example is the educationist (not educator) who deals with notions and gimmicks rather than people. Another is the physician or student who forgets that the technique is for a human purpose.

In medicine the dehumanizing process may take subtle form with devastating consequences. The ultimate is for patients to become "undesirable." While the position of being undesirable is an unwelcome eventuality in any interpersonal relationship, for a patient to be regarded by his physician as undesirable can be catastrophic. Not only may such a patient sense his situation with uneasiness, but in general he is likely to receive less than the best total care.

The patient's "undesirable" status takes several forms.

1. *Socially undesirable* refers to the patient who is irreconcilably different from the physician, eg the patient with alcoholism; old people in relation to the young physician; the long-haired attended by the older physician; uneducated patients; and patients who are dirty.

2. *Attitudinal undesirability* refers to the patient who is inadequately grateful, complains, appears to know too much, or corrects the student and house officer during his presentation.

3. *Physical undesirability* includes the finding of physical illness when none was suspected, or the reverse. And the patient who fails unwittingly to respond to intelligent treatment. Or the patient who has only an ordinary illness — eg a stroke.

4. *Circumstantial undesirability* refers to the innocent acquisition of undesirable status by being admitted after hours, or to a physician who feels put upon by the next admission.

5. By *distraction undesirability*, I refer to the fact that a patient may not fit with the interests and orientation of the times. His very status as a patient may simply place him outside the

mainstream. For example, to the research scientist without clinical interest who is *required* to attend the patient, the disinterest and sense of imposition are of negative value. The newer community health programs bear similar risk to the patient. A patient can become undesirable simply because, to some people, deep concern with the health problems of any given individual is unconsciously regarded as a digression from the "greater" problem and "higher" and "nobler" calling of the care of millions of people. We have gained the impression that, in some instances, it is almost as if one can love humanity with minimal direct concern for individuals.

For dehumanization to occur in medicine, there must be a soil of obtuse phoniness; otherwise the inherent humane aspects of the profession could not be threatened. Some of our symbols favor things rather than people. We may come to suffer from an erroneous expansive view of ourselves which I call Iatromegaly. When did we begin to place ourselves in the position of assuming rights to make human value judgments? When did we allow ourselves to become pompous and to begin to believe that we were special, that we belonged on a pedestal, that we were almost divine? There is no substitute in life and in a profession for experience. But how often do we really use the word *experience* for perpetuated error — how often do we engage in the "I'm having a lot of luck with rhubarb ointment" type thinking? Sometimes superspecialization is used as a status symbol by and for the physician. The late Sir Richard Asher tells a beautiful story of the hazards of overspecialization. He tells of a consultation report from an ophthalmologist which, paraphrased, states: "This patient has retinitis pigmentosa, which could be part of the Lawrence-Moon Biedl syndrome. Does the patient have polydactyly?" I hope my colleagues in ophthalmology forgive the example, but it was in England, and I did glorify the ophthalmologist earlier.

How does the dehumanization and phoniness develop? One explanation is that the hardening process occurs as a defense for the physician's life so often immersed in pain. The setting in so many fields is one of pain for patient and physician. I'm afraid that pain and tragedy for the patient not only stimulate fear and denial in himself, but have their effects on the physician as well. Compassion is surely elicited, but so may be fear. The latter can result in apparent



indifference. To the extent that *fear* and *indifference* predominate, the physician is less of a physician and less of a person. The protective mechanism, if it is such, fails.

If much or any of the dehumanization results from our own fears, we must find more useful and less destructive self-protective mechanisms. This begins with understanding the problem and appreciating the basic validity of President Truman's earthy remark that if you can't stand the heat, you don't belong in the kitchen.

#### OUR RESPONSIBILITIES

We talked about some of the dehumanization process that plagues us, that inhibits our very growing up as human beings, as humane physicians. It might be helpful to examine our responsibilities, because in meeting them perhaps we can get some glimpse of what we need to do to try to grow up.

*Responsibility to the patient.* This commitment has the highest priority and supersedes, but does not preclude, other obligations. What must we do to meet our responsibility? For example, what must we know about a patient with heart disease? Obviously, we must be able to establish an operational diagnosis; we must know the action and hazards of the medications we shall use in the treatment; and we must know the patient as a person: his or her fears, anxieties, goals, ambitions, and responsibilities, and also the socioeconomic setting in which the patient finds himself or herself. Can the patient afford the medications? Who will take care of the children if their mother is hospitalized? How much economic burden and worry rests with the sick breadwinner? And how may these factors influence the course of illness and treatment?

It is clearly not enough to be capable and knowledgeable in the area of making the "right" diagnosis of the nature of the heart disease, while ignoring the patient as a person. Surely disease would be an abstract notion of little interest to most of us in this room if it did not occur in people. On the other hand, it is not enough to be a kind, considerate, compassionate physician who holds the patient's hand while he or she dies of a curable form of heart disease because the physician did not suspect the right diagnosis.

It is our responsibility to provide knowledge and skill in the *total* sense.

But the body of knowledge is so vast that none of us can possibly hope to master it all. Therefore, we are also committed to our patients to know what we do not know and to ask for help under these circumstances. In our relationship with the individual patient, we are also committed to respect, honor, and guard the patient's confidence. We must accept this as a sacred trust. We may share our own problems with our spouse, but this does not include sharing a patient's personal problems.

*Responsibility to society.* The physician has responsibilities as an educated person, aside from his role as physician. As such, he or she should participate in the social, cultural, and educational life of the community.

As a physician, he has a special responsibility to know the health needs of his own community, to improve standards of public health and preventive medicine, and to improve community health service.

*Responsibility to colleagues.* There is a great tradition in medicine for teaching each other and learning together in a life dedicated to continuing education. We literally owe each other the sharing of knowledge, information, and insights.

We also owe our colleagues fairness, honesty, and open-mindedness in areas of professional disagreement. We do not, however, owe them protection in their incompetence or dishonesty.

*Responsibility to our families.* We have the same responsibility as all husbands, wives, parents, and children; but our responsibilities take on special meaning in some ways. The world of the medical student and physician is an amazing one: one which deals with the substance of life and death, one which deals with man's inner secrets, one which carries a commitment and dedication shared by few other vocations. This atmosphere is both confining and broadening.

Most physicians are men, and this engrossing life can exclude wives who in our earlier years as students and house officers may live in the world of a typewriter to support us or may live isolated in a world of diapers. The man must recognize the issues, recognize and appreciate his wife's commitment, must express love and appreciation, and must find ways to keep his wife's intellectuality alive no matter how fatigued or overwhelmed she may be and without regard to her areas of interest. When the struggle is over and the goal reached, too often people



find that only the struggle has kept them together.

The woman in medicine has far greater opportunity and freedom than used to be the case, but true equality has not yet been hers. But that too will come, because it is right and it must. She must be free to excel; and her husband, physician or not, must not be frightened or feel emasculated even by greater position and earning power should they be hers. And in our family units the woman also has responsibilities to show appreciation, love, and respect.

In other words, our families are also human and deserve dignified, human treatment.

*Responsibility to oneself.* The physician is only human, and he deserves the same as other humans. He has human wants, needs, frustrations, anxieties, and fears. If he needs help, he should seek it as he would advise others to do.

In addition the physician needs pleasure sources — we have already mentioned the key role of family. Even more is needed by most of us. It is important to have a small number of civilized and real friends: people who share joy and sadness; people who take us as we are — mixtures of good and not so good; people who understand our vulnerabilities as members of the species; and people with whom we don't play doctor. And we need non-medical interests, including something for its own fun sake and not simply for its value of getting us away from the grind. I ask every patient I see: "What do you do for fun?" The most common replies include: "Would you repeat that question?" "Lots of things." "Nothing." Or a stare suggesting that I had just used a three-letter dirty word. And my physician patients have not differed. Fun is not by definition evil. And we must not postpone the pleasure. Millar wrote: "Life is something that happens to you while you are making other plans."

How does one acquire the attributes necessary to meet these obligations as physician and person?

A few things become obvious immediately:

1. The educational process begins long before the physician enters medical school. The attributes of honesty, integrity, and humility should have been developed by age six; all that medical school can do is put them in sharper perspective and focus them on a particular series of relationships and situations.

2. The same may be said to some extent of an interest in human beings and their emotional and social problems. But in medical school this

interest and intuition can be the basis for learning how to evaluate people and how to help them best. An interested, compassionate layman can administer sympathy; a physician should be able to do that and much more. This can be taught and learned.

3. A respect for all human beings is presumably present in all of us; but in medicine, we have to learn *not* to judge the worth of a man in the patient-doctor setting. All of us have the background and basis for accomplishing this: one can lean on ethical and moral principles to establish the ground rules of such a relationship; or, for the religiously inclined, one can lean on the concept that all men are created in God's image. Regardless of how respect for man is accomplished, it must be done.

Ours is a profession of service — a fascinating, consuming, exciting, productive profession of service. In these times of emphasis on stark realism, one may be accused of melodrama when one refers to medicine as a "calling." I am not at all embarrassed to believe that medicine is a most noble calling.

#### SUMMATION

Very early today, I defined growing up as dedicated pursuit of totally human purposes. While it is difficult to define the term *human purpose*, I have accepted what skilled and humanistic philosophers and theologians have sifted out for us for many years. In contemporary times Buber has expressed this very well, I think, in his three themes for human consciousness: (1) *concern for justice*, (2) *compassion*, and (3) *respect for scholarship* — including truth. We next explored certain aspects of the dehumanization process, the negative input. And then we began our exploration of how we can stay in pursuit of human purposes. We had a brief look at our responsibilities, as physicians and people, and at the attributes necessary to meet our responsibilities. I think it is evident that the real effort to fulfill these responsibilities to patients, society, colleagues, family, and oneself takes one a considerable distance in the pursuit of human purposes. In short, to grow up as a physician requires the acquisition of skill, technical capability, experience, and growth as a human being. To mature as a human being is to recognize and strive for the realization of life's human purposes, while recognizing the reality and the strength of the dehumanization process.



## Want To Be / PAPPER

Frankly I believe that to diminish the dehumanization phenomena is an undertaking of enormous proportions. I think we must deal not only with ourselves, as we have emphasized, but also rather extensively with our environment. We have to reject not only physical pollution but also emotional, social, and intellectual garbage. We must reject the spirit of compromise on issues concerning human life. At all of our too many meetings in and out of academia where discussion often resembles an internunciate pool without any efferent pathway, and in all our professional involvements, we must ask ourselves and others how a particular issue serves overall human purposes.

To focus only briefly on the academic scene:

One of my great disappointments after so many years in the tower is that I have seen academic medicine fall short of appreciating that its purposes are fundamentally and totally human. While commitment to human purposes can be expressed in research, community programs, and education — *all* is lost if we do not make the most obvious human concern our primary one: *our patients*. And thereafter have human concern for each other and ourselves. But I am optimistic for the future.

I do hope all of you at all ages grow up well, because it will serve you well in the end. As stated in Martial (A.D. 86), "To be able to enjoy one's past life is to live twice." □

921 N.E. 13th Street, Oklahoma City, Oklahoma 73104.

### Continuing Medical Education Course

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### He a Source of Information?

Yes, with certain reservations. The average sales representative is as a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

### Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility

of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone

in the health care field, whether they be general practitioners, surgeons or salesmen.

### Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just "pushers" of their drugs.

### The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and determined his potential role as an educator.

### Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and

thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—i.e., the patients—will be.

### Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that informa-

tion must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.





## News From The Oklahoma State Department of Health

### HEMOGLOBINOPATHY TESTING PROGRAM

The first of July in 1972, a statewide Sickie Cell Anemia Detection Program was initiated through the Chronic Disease Division of the Oklahoma State Department of Health on a county by county basis. Any individual 12 months or older was offered the opportunity of being tested for sickle cell trait or disease by hemoglobin electrophoresis. All specimens obtained through mass testing clinics in each county were sent to and processed by the Oklahoma State Department of Health Laboratory.

Individuals found to have any hemoglobin variant in addition to hemoglobin-S on the initial test were given a second test before any

confirmation was made. After identifying the hemoglobin variant based on a second test, genetic counseling was provided to each individual (if a child, to the adult member of his family) explaining in detail the results of the test and answering all questions. Those individuals found to have a normal type hemoglobin on the initial test were notified by mail.

Although the initial testing program functioned through massive testing clinics with only one disease in mind, sickle cell tests are routinely available upon request at any one of the 60 county health departments in Oklahoma as a part of their Multiphasic Screening Clinics. □

### OKLAHOMA HEMOGLOBINOPATHY TESTING PROGRAM RESULTS

July 1, 1972 to June 30, 1974

Normal (Negative)	36,437
Hemoglobin variances (Including Hb-S)	4,042
<b>Total number individuals tested</b>	<b>40,497</b>

### COMMUNICABLE DISEASES IN OKLAHOMA FOR AUGUST, 1974

DISEASE	August 1974	August 1973	July 1974	Total To Date	
				1974	1973
Amebiasis	6	5	4	20	25
Brucellosis	1	1	2	6	5
Chickenpox	6	9	11	806	1302
Encephalitis, Infectious	2	26	8	41	89
Gonorrhea (Use Form ODH-228)	962	986	1204	7383	7335
Hepatitis, A, B, Unspecified	60	51	78	703	730
Leptospirosis	—	—	—	1	—
Malaria	—	—	2	3	2
Meningococcal Infections	1	3	2	15	28
Meningitis, Aseptic	8	37	11	45	82
Mumps	11	20	8	369	432
Rabies in Animals	15	4	11	112	137
Rheumatic Fever	2	2	—	9	12
Rocky Mountain Spotted Fever	7	6	18	53	68
Rubella	8	2	3	44	179
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	1	2	1	25	53
Salmonellosis	31	42	27	172	165
Shigellosis	20	10	13	108	149
Syphilis, Infectious (Use Form ODH-228)	6	11	13	93	120
Tetanus	1	—	—	1	3
Tuberculosis, New Active	25	27	41	216	208
Tularemia	3	1	4	13	19
Typhoid Fever	1	—	1	2	2
Whooping Cough	2	2	4	14	20



## Health Sciences Center Information Campaign Progressing

An informational campaign to explain the plight of the OU Health Sciences Center is being waged by the OSMA on a statewide basis. A special slide presentation outlining the history of the center, its current problems, and offering solutions, is being shown to audiences throughout the state.

The special audio-visual presentation is a result of hundreds of man hours on the part of the OSMA's Medical Center Liaison Committee chaired by Doctor C. S. Lewis of Tulsa. It was made possible when the association's board of trustees pledged \$5,000 out of its operating budget to launch the informational campaign. In addition, nearly twice that amount was received in voluntary contributions from OSMA members.

The presentation is already being seen by large audiences in Ada, Lawton, and several other Oklahoma cities. It is scheduled for showing in Oklahoma City on October 22nd and in Bartlesville on the 30th. Additional towns and dates will have been announced by the time this article is published. The committee wishes to make the presentation in as many major medical and population centers as possible, including Ardmore, Elk City, Enid, McAlester, Muskogee, Norman, Ponca City, Shawnee, Stillwater and Woodward.

The presentation will also be available, on a limited basis, for showing to civic clubs, Chambers of Commerce, etc.

The audio-visual presentation points out that for the past two years the health sciences center has been barraged with publicity about its "crisis." It has been subjected to numerous special studies, investigating committees, accusations and resignations.

OUHSC campus in Oklahoma City actually contains five major colleges. The most familiar are the College of Medicine and the College of Nursing. However, there are now in operation the new College of Dentistry, the College of Health and Allied Health, and the Graduate College of Medicine.

The physical facilities of the center are better than they have ever been and are continuing to improve. Much of this improvement was brought about by the passage, in 1968, of the "hero" bond issue. The College of Nursing is currently sharing its new home temporarily with the College of Dentistry until the new dental building is completed in 1976.

The total number of students is growing constantly as a result of the planned program to produce more health related personnel. This, added to the proliferation of new programs and construction, was suddenly complicated by the withdrawal of federal monies for health care construction and research projects. The result was a financial squeeze . . . a squeeze between operating costs going up and federal income going down.

The audio-visual presentation admits that the OUHSC did not have a financial management system that could react quickly and accurately to the sudden financial squeeze. Much of the problem revolved around Everett Tower, the new portion of the University Hospital.

The tower was designed to house many of the services required by a 1,000-bed hospital, the ultimate goal of the University Hospital. It was to be the first phase of a three-phase program and housed food services, office space, laboratories, storage areas and many others.

Now it appears that the second and third phases of the hospital plan will never be built. These phases were to contain the majority of the patient room facilities. As a result, University Hospital today contains only 240 beds with a service core facility to serve 1,000 beds. This places an obvious severe economic strain on the institution. At the same time two other economic factors affect the hospital . . . the cost of care for the medically indigent and the educational costs incurred because it is a teaching hospital.

Doctor Jack L. Richardson, President of the



OSMA, states, "For many, many years now, University Hospital has absorbed an abnormally high number of medically indigent patients." These are defined as those persons who are not covered by some type of medical insurance, either government or private, and cannot afford to pay for their own medical care. At the same time it is estimated that approximately 28% of the hospital's total budget of \$18 million are educational in nature.

Doctor Richardson pointed out that the educational costs must be made a part of the OUHSC's budget and must be so recognized by the university, the OU Regents, the State Regents and the Oklahoma Legislature.

In regard to the indigent care problem the association president said, "We suggest that the leadership of the Oklahoma Legislature should immediately convene a special indigent care study group of private citizens and public officials who have the special knowledge to consider new methods of dealing with the charity care question. This group's findings should be ready for the legislature when it convenes in January."

In specific reference to Everett Tower the doctor said, "We recommend that the hospital's board of trustees develop innovative ways to share services with other nearby institutions, namely Children's Hospital . . . Veterans Hospital . . . the new Presbyterian Hospital . . . and Oklahoma Medical Research Foundation. There are many ways, we believe, that through such sharing of services that costs can be reduced and that the hospital's economic future can be strengthened. We recognize that these cooperative sharing efforts are answers only to the short term problem. The long range solutions, due to future growth, could require construction of phase two and three of the hospital."

Doctor Richardson closed his portion of the presentation by stating, "University Hospital is vital to the business of medical education at the Health Sciences Center. It must be maintained and operated as a first class medical institution and we believe the plans which we have outlined will go far in helping University to reach its objectives."

C. S. Lewis, MD, Chairman of the OSMA's Medical Center Liaison Committee and Coordinator of the Informational Campaign spoke directly to the problem of maldistribution of

health care personnel and the health center's ability to train such persons. He pointed out that at the present time Oklahoma has 85 first-year residency positions available to its new doctors, virtually all in Oklahoma City and Tulsa hospitals. He then went on to say, ". . . we propose that the number of first-year residency programs in Oklahoma be increased to match the number of graduates, which will be 200 per year by 1979. We also propose that the cost of all residency programs be partially borne by the state through higher education dollars. A residency program is indeed a final part of a higher education process for physicians. The cost of these programs is currently being paid by private hospitals which, in turn, must pass the cost on to paying patients. This, we feel, is not just. We propose that the state assume 50% of these costs which will encourage a major expansion of existing residency positions."

The Tulsa physician then went on to endorse a new program recently started by the OU College of Medicine. "This program calls for increasing by about 400% the number of family practice residency programs in the state. Family practice physicians are specially trained to provide extensive primary care and they normally establish practice in the non-metropolitan areas of the state."

The new OU plan calls for establishing residency programs in such cities as Enid, Ada, Lawton, Ardmore, McAlester, Muskogee, or other cities such as Shawnee, Bartlesville, Chickasha or Stillwater, which meet the established criteria. While Oklahoma City and Tulsa now produce a total of eleven family practice graduates per year, the new satellite plan would add 36 more family practice graduates for a total of 47 per year.

"This nation will never return to the days when every small village had its 'town doctor,'" Doctor Lewis said, "Yet we cannot afford to ignore the need for more physicians in non-urban areas. We believe the OU satellite system, coupled with a new program of producing physicians assistants, will provide a maximum of health care delivery to the people of Oklahoma. We urge your support of both this plan and our proposal to increase residency programs through financial support by higher education."

The slide presentation then points out, "Compared with the national average, Oklahoma is not spending enough on medical education. In a recent study, the Association of American Medical Colleges reported that



Oklahoma spends \$9,200 per year to educate a physician. The nationwide median cost is \$17,500 per student.

"We of the association are not recommending a specific budget to the legislature nor to the center. But we do recommend that state support be granted on the basis of potential rather than problems . . . on the basis of true need. With every new classroom completed, with every new student added, costs increase and these costs must be recognized and funded if we are to achieve our goal of providing first class health care for the people of Oklahoma. We ask that you lend your support through direct communications with your elected representatives."

The presentation closes by stating, "We believe there is no priority higher than the health of our people. That is why we urge your concern, your understanding and your support of these programs and solutions. We believe the health sciences center is one of the state's greatest assets. Its major problems are history. Its foundation for future service to the people is sound. Its needs for future support are critical." □

## Alcoholism Topic For Clinical Society Fall Conference

"Women, Adolescents and Alcohol . . . On the Rocks," will be the topic for the Oklahoma City Clinical Society's Fall Conference November 8th-9th, 1974 at the Lincoln Plaza Convention Center.

The meeting, being co-sponsored by the OU Health Sciences Center Postgraduate Department, will precede the OU-Missouri game on November 9th. Missouri physicians have been invited to attend the fall conference and then journey to the Norman OU campus by bus late Saturday morning.

The formal program will start at 1:00 p.m. on Friday afternoon, November 8th. The first presentation will be "Alcohol Dependency in Women; Problems of Management in Daily Practice."

Other topics to be scattered over the two half-day sessions will include Alcohol Consumption by Adolescents, Endocrine Changes and Behavioral Responses in Women, Effects of Alcohol at Various Points in the Menstrual



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Cycle, and Clinical Pointers in the Management of Alcohol Problems.

Registration fee for the meeting is included in the Oklahoma City Clinical Society members' 1974 dues. The registration fee for non-members of the society is \$25.00. This fee includes breakfast, social hour and transportation to the game for husbands and wives.

The program is acceptable for five prescribed postgraduate study hours by the American Academy of Family Physicians.

Official welcome to the fall conference will be given by Arnold G. Nelson, MD, current President of the Clinical Society. James D. Funnell, MD, is Director of Clinics; Kenneth Whittington, MD, Vice-President; Joe M. Parker, MD, Secretary; and Marion C. Wagon, MD, Treasurer.

Persons interested in attending the fall conference should contact the Oklahoma City Clinical Society office at 601 Northwest Expressway, Oklahoma City, Oklahoma, 73118. Telephone Area Code 405, 843-5619.

The entire program for the two half-days is as follows:

November 8th: 1:00 p.m.

"Alcohol Dependency in Women; Problems of Management in Daily Practice" — John A. Blaschke, MD, Oklahoma City.

"Women, Self-Perceptions and Alcohol Use" — Barry Kinsey, PhD, Professor of Sociology, Tulsa University.

"Alcohol Drinking During Adolescence; Extent of the Problems and Aspects of Prevention and Management" — Povl Toussieng, MD, University of Oklahoma.

"Endocrine Changes and Behavioral Responses in Women. Implications for Drinking Behavior" — Donald Broverman, PhD, Worcester State Hospital, Boston, Massachusetts.

"Panel Discussion: Women, Adolescents and Alcohol Abuse" — Doctors Blaschke, Kinsey, Toussieng and Broverman.

November 9th: 9:00 a.m.

"Effects of Alcohol at Various Points of the Menstrual Cycle" — Ben M. Jones, PhD, University of Oklahoma.

"The Wife of the Alcoholic: Culprit or Vic-

tim?" — Alfonso Paredes, MD, University of Oklahoma.

"Alcohol, Sleep and Women" — Boyd K. Lester, MD, University of Oklahoma.

"Clinical Pointers in the Management of Alcohol Problems" — Edward Gottheil, PhD, Jefferson University, Philadelphia, Pennsylvania. □

## Allergy Program To Be Offered in November

Latest information about diagnosis and treatment of allergy problems will be presented to physicians November 15th-16th as a part of a new continuing medical education course at the University of Oklahoma Health Sciences Center.

The course, entitled "Allergy in Clinical Practice," will be held at the Howard Johnson's Motor Lodge, SH66 and Lincoln Boulevard in Oklahoma City. This symposium is being sponsored by the Allergy Division of the Health Science Center's Department of Medicine.

Cost of the course, limited to 100 physicians, is \$90 for practicing physicians and \$45 for residents and interns. Doctors' wives may attend the symposium free of charge.

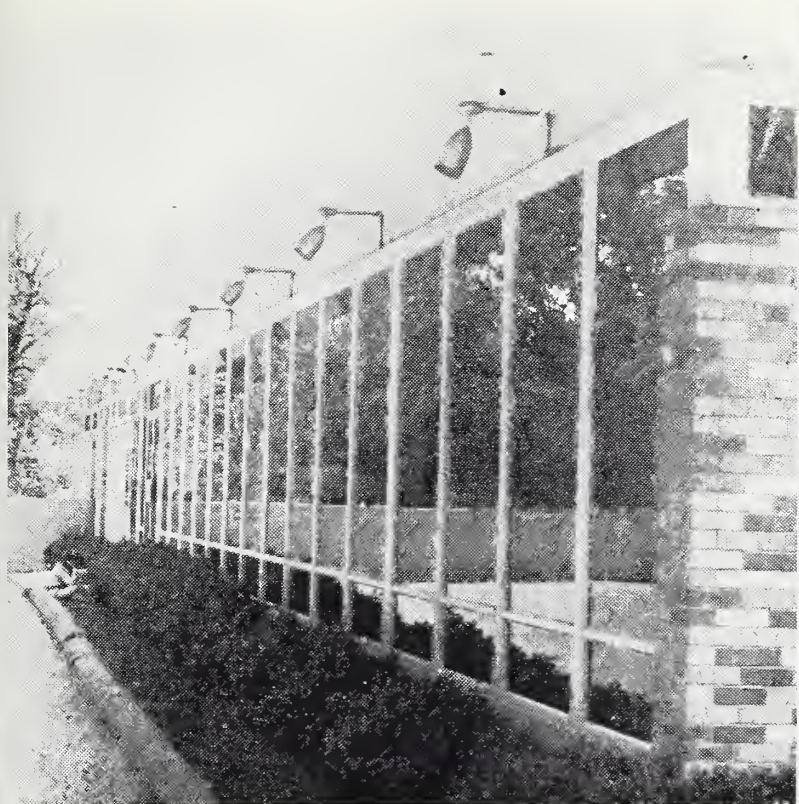
Information on the course is available from the Office of Continuing Education for Physicians, University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City, Oklahoma 73190.

Guest speaker for the program will be Daniel J. Stechshulte, MD, Associate Professor and Director of the Division of Allergy, Clinical Immunology and Rheumatology for the University of Kansas Medical Center's Department of Medicine.

Subjects to be covered include Newer Approaches to Bronchial Asthma and Treatment of Hay Fever, Asthma, Anaphylaxis, Drug Allergy, Insect Hypersensitivity, Nasal Polyps, Aspirin Sensitivity and Urticaria. Goal of the course is to provide practical information about the most commonly encountered clinical problems in allergy.

The symposium is sponsored in part by grants from the Allergy Laboratories, Inc., of Oklahoma City, and Syntex Laboratories, Palo Alto, California. □





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## OUHSC Provost Search Continues

Visits to the Health Sciences Center campus by prospective candidates for the position of Provost for the Health Sciences at the University of Oklahoma were made during late September and early October according to OU President Paul Sharp.

By the time this news article is printed, the new Provost may have already been named. Doctor Sharp said that the Provost Search Committee is hopeful that a permanent Provost for OUHSC could be named by mid-October.

Doctor Oscar Parsons, Chairman of the Search Committee and Vice-Chairman of the OU Department of Psychiatry and Behavioral Sciences, said the field of candidates for the post had been narrowed to eighteen persons in mid-September. The post is currently being filled by acting Provost Doctor William E. Brown.

One of the first candidates to visit the Oklahoma City campus was Richard Wilbur, MD, former Deputy Executive Vice-President of the American Medical Association. Doctor Wilbur had also served as an Undersecretary for Health in the Defense Department.

Doctor Parsons was appointed to serve as Chairman of the Provost Search Committee to replace Thomas N. Lynn, MD, after Lynn was appointed Acting Dean of the OU College of Medicine upon the resignation of Robert Bird, MD.

Other members of the Provost Search Committee are Sidney Traub, MD, Professor and Head of Radiological Sciences; Doctor Walter Dilts, Professor of Operative Dentistry and Coordinator of Clinics; Doctor Lawrence Scott, Chairman of Microbiology and Immunology; Lorraine Singer, Assistant Dean of the College of Nursing; Kathryn B. Sohler, Associate Professor of Biostatistics and Epidemiology; Raymond Weeks, Oklahoma Public Health Association member; Arnold G. Nelson, MD, President-Elect of the Oklahoma State Medical Association; and Juanita Proctor, Oklahoma State Nurses Association.

Other members of the committee include Doctor James Saddoris, Immediate Past-President of the Oklahoma State Dental Association; Dean Crislip, Kerr-McGee Corporation Representative; Doctor Teague Self, Regents Professor of Zoology; Jody Rice, medical

student; Sandy Irving, Environmental Health Student; Edward Daley, Vice-President of Public Service Company of Tulsa; and Nancy Condit, Health Sciences Center Non-Academic Personnel Representative.

Doctor Parsons stated, the "breath and diversity of the committee reflects the need that Provost leadership qualities and style elicit support of people both inside and outside the university structure."

The committee chairman said that the person selected as Provost will be responsible to the OU President for the Academic Programs offered by the Colleges of Nursing, Dentistry, Health and Medicine, as well as the Graduate College. □

## OSMA South American Tour Filling

A two-week air-sea cruise along the "sunshine coast of South America," being sponsored by the OSMA, is filling rapidly. Oklahoma physicians will depart from Tulsa and Oklahoma City on January 28th for two weeks on the elegant Stella Oceanis Cruise Ship.

The tour will fly from Oklahoma via chartered Trans International Air Lines "stretch" DC-8 jet to Montevideo, Uruguay. There the travelers will board the luxury ship and sail into summer.

Throughout the cruise there will be a distinguished faculty to deliver 28 hours of classes on "Emergencies in Medical Practice." While most of the classes will be conducted on shipboard, arrangements have been made with local professors in medicine to conduct several workshops in the various ports of call.

During the cruise Oklahomans will visit Buenos Aires and Mar Del Plata, Argentina; Sao Paulo, Santos, Rio De Janeiro, Vitoria and Salvador (Bahia) Brasil. A special side trip is being offered to Brasilia and another to Iguassua Falls, Brasil.

Physicians interested in participating in the South American Cruise should contact the OSMA office at 601 Northwest Expressway, Oklahoma City, Oklahoma. Prices of the cruise range from \$995 for an inside stateroom up to \$1,895 for a deluxe suite.

A colorful brochure on the tour will be sent upon request.

The tour will return to Tulsa and Oklahoma City on February 10th. [



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## Arthritis Course Set For Ardmore

"Arthritis for the Practitioner" is the title of a six hour continuing medical education course being conducted on Saturday, October 26, at Lake Murray State Lodge, Ardmore.

Sponsored by the Oklahoma Rheumatism Society in conjunction with the Arthritis Foundation and the Office of Continuing Medical Education of the OU College of Medicine, the course is accepted for six hours credit for the AMA Physicians Recognition Award.

Site for the course is Lake Murray State Lodge near Ardmore. The lodge is owned and operated by the State of Oklahoma.

Persons interested in attending the course should contact Doyle Bare, Executive Secretary, Oklahoma Rheumatism Society, 3313 Classen Boulevard, Suite 209, Oklahoma City, Oklahoma 73118.

Speakers for the day and their topics are as follows:

J. Robert Cochran, MD, in the private practice of surgery of the hand, Fort Worth, Texas, will discuss "Reconstruction of the Hand."

Chester W. Fink, MD, Professor of Pediatrics at the University of Texas Southwestern Medical School, Dallas, Texas, will speak on "Juvenile Rheumatoid Arthritis." The doctor is also Director, Juvenile Arthritis Clinic, Texas Scottish Rite Hospital for Crippled Children.

Robert G. Godfrey, MD, Chief, Arthritis Section, University of Kansas Medical Center, Kansas City, Kansas, will discuss "Ankylosing Spondylitis."

Hugo E. Jasin, MD, Associate Professor of Internal Medicine, University of Texas Southwestern Medical School, Dallas, Texas, will speak on "Systemic Lupus Erythematosus."



Charlie J. Smyth, MD



Robert G. Godfrey, MD

Lewis J. Levy, MD, Chief, Orthopedic Department, John Peter Smith Hospital, Fort Worth, Texas, will discuss "Arthroplasty of the Knee."

Steven Tkach, MD, in the private practice of orthopedics, Oklahoma City, will discuss "Surgery of the Hip."

Charlie J. Smyth, MD, Professor of Medicine and Head, Division of Rheumatic Diseases, University of Colorado, Denver, Colorado, will discuss "Gout and Pseudogout."

Paul C. Williams, MD, in the private practice of orthopedic surgery, Clinical Associate Professor Orthopedic Surgery, University of Texas Southwestern Medical School, Dallas, Texas, will present "Low Back Syndrome." □

## Search Committee Named For New OU Dean

Members of a search committee to seek a new Dean for the College of Medicine at the University of Oklahoma Health Sciences Center were chosen in mid-September by OU President Paul F. Sharp.

The seven-member committee will be chaired by Richard T. Coussons, MD, Professor of Medicine at the Health Sciences Center and Chief of Medical Services at Oklahoma City's Veterans Administration Hospital.

Thomas Lynn, MD, is serving as acting dean while nominations to fill the dean's chair vacated by Robert M. Bird, MD, are being sought. Doctor Bird resigned effective September 1st to accept the Directorship of the Lister Hill National Center for Biomedical Communications in Bethesda, Maryland.

According to Doctor Coussons, a nationwide search extending several months is anticipated before any recommendations are made to Doctor Sharp by the search committee. "We are actively seeking input from people within the OUHSC campus structure and outside our community for possible candidates," Doctor Coussons said.

Other members of the committee appointed by Doctor Sharp are Robert G. Tompkins, MD, Tulsa; Mrs. Nancy Davies, former OU Board of Regents President; Mark A. Everett, MD, Professor and Head of the Department of Dermatology; James Merrill, MD, Chairman of the Department of Obstetrics and Gynecology; Doctor Jo Anne I. Moore, Chairman of the Department of Pharmacology, and Larry Pennington, fourth-year medical student. □



## Immunization Action Month Is October in Oklahoma

October is Immunization Action Month. The program, part of a national effort, is sponsored in Oklahoma by the OSMA and the Oklahoma State Department of Health Immunization Program.

Nationally the program is being sponsored by the AMA, the American Academy of Pediatrics, American Association of Family Physicians, Association of State and Territorial Epidemiologists, Association of the National Center for Voluntary Action and numerous pharmaceutical companies.

The purpose of an immunization program is to locate and immunize persons susceptible to childhood diseases that are preventable through immunizations. These diseases include measles, rubella, polio, diphtheria, tetanus, and pertussis.

All physicians are encouraged to initiate a working audit of patient immunization records to discover the under-immunized person. A special notation on patient record should be made if it is determined that the patient is susceptible to any or all of the childhood diseases.

A statewide information campaign aimed toward patients is asking that they perform their own vaccination audit on themselves and their children. If there are questions, parents have been asked to contact their physician or public health officers for aid.

National immunization levels for children in the one to four age group are sufficiently low to cause public health officials great concern. The low immunization level creates a potential threat of epidemics.

The National polio level of immunization is currently 60.4%, the lowest in the past nine years. The Level of DPT immunization is 75.6%, the lowest since 1966, while the level for measles is 21.2% and rubella 55.6%. None of these immunization levels will prevent epidemics.

Oklahoma has a particular reason for concern. The immunization level for preschool children for polio is 66.6%, measles is 69.1%, rubella is 64.8%, and DPT is 78.6%. While several state levels are somewhat higher than national levels, polio should be of great concern to parents and physicians in Oklahoma.

The major emphasis of Immunization Action Month in Oklahoma has been directed toward preschool children. The program is

encouraging a systematic review and updating an immunization status for those currently in private or public health care systems. □

## AMA To Develop Guidelines For PSRO Hospital Care

The American Medical Association has been named by the federal government to coordinate development of a set of guidelines for evaluating medical care in hospitals. A contract for \$995,000 for the 18-month project was signed by the AMA and HEW.

National medical specialty societies actually will develop guidelines for the medical conditions in their areas of expertise.

Each specialty society will first determine which medical conditions account for three-fourths of all hospitalization within the specialty. The specialty group will then develop guidelines for screening appropriateness, necessity and quality of medical services in the hospital for each condition.

The signing of the contract came after the AMA House of Delegates voted at its Chicago Annual Meeting to seek to exert AMA influence on behalf of regulations to govern professional standards review organizations, known as PSROs. It is anticipated that the initial publication of the guidelines will be developed for distribution at about the eighth month of the project, with revisions and refinement distribution in approximately 18 months.

The AMA stressed that the new model sets of criteria will not be mandatory for each local PSRO group, but will serve as guidelines which the groups will adapt to their local situations. □

## Medical-Legal Publication Seeks Manuscripts

A Journal devoted to Medical-Legal subjects is now being published. *The American Journal of Law and Medicine*, a scholarly journal published by the American Society of Law and Medicine, Incorporated, is seeking manuscripts for possible publication.

Qualified individuals are invited to submit manuscripts relating to legal medicine or the legal or insurance aspects of health care delivery, for consideration by the journal's board of editors. Manuscripts may be submitted to, or further information obtained from: John A. Norris, JD, Editor-in-Chief, *American Journal of Law and Medicine*, 454 Brookline Avenue, Boston, Massachusetts, 02215. □



# Oklahoma Summit Scientific Papers

## AUDIO CASSETTE RECORDINGS AVAILABLE

- ☐ ACUPUNCTURE - (2 cassettes)
  - "Modern Acupuncture and Western Medicine" - Yiu Wing, MD
  - "Acupuncture in Prospective With Emphasis on Rheumatic Disease and Complications of Acupuncture" - Richard Droeming, MD
- ☐ RADIOLOGY - (1 cassette)
  - "Is This Chest Film Normal" - JF Wiot, MD
- ☐ SUMMIT LUNCHEON - (1 cassette) - Russel B. Roth, MD
- ☐ PSYCHIATRY - (3 cassettes)
  - "Practical Psychotherapy Techniques" - Beverly T. Mead, MD
  - "How to Mend Your Old Crocks" (panel)
  - "Problems of the Adolescent" - Dr. Mead
- ☐ COLON AND RECTAL CANCER - (2 cassettes)
  - Principles of Colostomy Surgery - James Hartsuck, MD
  - "Fiberoptic Colonoscopy" - Max Gregory, MD
  - "Management of Colon Polyps" Robert Freeark, MD
  - "Screening for Colon Cancer" - Freeark
  - "Treatment of Advanced Colon and Rectal Cancer" Rupert Turnbull, MD
  - Panel Discussion
- ☐ SUDDEN UNEXPECTED DEATH - (2 cassettes)
  - Sudden Unexpected Death - Identification of Patients At Risk - Louis Kuller, MD
  - "Sleep, Stress, and Sudden Death" - G. C. Gunn, MD
  - "Clinical Considerations in Prevention of Sudden Death" - Leonard A. Cobb, MD
  - Panel Discussion
- ☐ OBSTETRICS AND GYNECOLOGY - (1 cassette)
  - "Abnormal Pap Smears 'What To Do When'" - Preston DeShan, MD
  - "Management of Toxemia of Pregnancy" - Norman F. Gant, Jr., MD
- ☐ CURRENT CONCEPTS AND TREATMENT OF DIABETES - (2 cassettes)
  - "Diagnosis of Early Adult-Onset Diabetes" - Edgar A. Haunz, MD
  - "Current Concepts of Treatment for Diabetic Retinopathy" - Charles P. Wilkinson, MD
  - "Newer Concepts of Treatment of Diabetes" - Edgar A. Haunz, MD
- ☐ VERTIGO - (2 cassettes)
  - "Dizziness from Vestibular Origin" - Willard B. Moran, Jr., MD
  - "Dizziness from Ocular Imbalance" - Thomas E. Acers, MD
  - "Dizziness from Systemic Problems" - Richard Dotter, MD
  - "The Dizzy Patient" (Panel)
- ☐ SUMMIT LUNCHEON: HARRY SCHWARTZ, PHD
- ☐ ENDOCRINOLOGY - (2 cassettes)
  - "Basic Screening Procedures for Endocrinological Diseases in the Outpatient" - Stephen Landgarten, MD
  - "Newer Concepts in the Regulation of the Menstrual Cycle" - A. Scommegna, MD
  - "Practical Endocrinology" - (panel)
- ☐ ENDOMETRIAL CANCER - (2 cassettes)
  - "Review of Histological Changes in Borderline Endometrial Lesions"
  - "Endometrial Diseases in Young People" - James A. Merrill, MD
  - "Diagnosis of Endometrial Cancer" - Robert H. Messer, MD
  - "Management of Endometrial Cancer" - Preston W. DeShan, MD
  - "Treatment of Advanced Endometrial Cancer" - Robert H. Messer, MD
  - Panel Discussion
- ☐ OTOLARYNGOLOGY - (2 cassettes)
  - "Fracture of Frontal Bone" - G. English, MD
  - "Cervical Esophagostomy in Head and Neck Tumors" - Gerald M. English, MD
  - "Inflammation" - Gerald M. English, MD
- ☐ NEPHROLOGY - (2 cassettes)
  - "Management of the Patient With Chronic Progressive Renal Failure" - H. E. Ginn, MD
  - Nephrology Panel Discussion
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## **Cancer Society and Medical Research Foundation Sponsor Educational Meeting**

The American Cancer Society and the Oklahoma Medical Research Foundation have jointly supported a unique educational program for doctors and nurses of Oklahoma. The program is in support of and closely allied to a breast cancer Network Demonstration Project which was recently funded by the National Cancer Institute.

The project has 23 hospitals in the network and has as its functional basis a Developmental Therapy Committee and a Committee of Consultants. The Developmental Therapy Committee is composed of numerous people in the research and academic fields as well as certain interested medical practitioners. The Consultants Committee has in its membership numerous surgeons, radiation therapists, medical oncologists, pathologists and radiologists, most of whom are in private practice but with some members allied to the Oklahoma University Health Sciences Center and the Oklahoma Medical Research Foundation.

The meeting has been designed to integrate the relationships of various medical subspecialists toward a true multi-disciplinary approach in the management of breast cancer and to develop areas and methods of breast cancer control. The meeting will be a day-long meeting with four distinct sessions encompassing biological behavior and tumor classifications, primary therapy, adjuvant therapy, rehabilitation, and treatment of advanced disease.

Twelve speakers comprise the faculty and include four speakers from widely separated areas of the country. Doctor Nancy Warner, Professor and Chairman of the Department of Pathology of the University of Southern California will speak on the pathology, classification, and prognosis of various types of breast cancer. Doctor Jerome Urban, Memorial Hospital in New York City, will speak on a rational approach to the treatment of breast cancer; Doctor William Powers, Mallinkrodt Institute of Washington University in St. Louis, Missouri, will speak on radiation therapy; Doctor Barth Hoogstraten, Chairman, Southwest Oncology Group and Professor of Oncology at the University of Kansas, will speak on hormonal and non-hormonal chemotherapy of advanced breast cancer.

The remaining speakers have been chosen

from both the health sciences center and health care delivery centers in the State of Oklahoma. These will include G. Rainey Williams, MD, Professor and Chairman of the Department of Surgery; Charles Marshall, MD, Associate Professor, Department of Pathology; Perry Lambird, MD, Pathologist at Presbyterian Hospital; Frank McGregor, MD, Director of Medical Education, Baptist Hospital; Stephen Acker, MD, Associate Professor of Radiation Therapy, University of Oklahoma; James Hartsuck, MD, Clinical Associate Professor of Surgery, University of Oklahoma and Arthur F. Hoge, MD, Oklahoma Medical Research Foundation and University of Oklahoma.

A report of the National Breast Cancer Task Force meeting held in Washington, D.C., on September 30th, 1974, will be presented by Robert Ellis, MD, Tulsa, and Joseph Parker, MD, Oklahoma City. Following a discussion and review, summary and conclusions will be presented by Doctor Williams. □

## **Unity Orientation Project Planned for Medical Students**

An educational program for pre-clinical medical students based in community hospitals and group practice clinics is being considered by the OSMA in conjunction with the Oklahoma Chapter of the Student American Medical Association.

SAMA hopes to institute the "Medical Education and Community Orientation Project," known as MECO, in Oklahoma in the summer of 1975.

MECO enables both practicing physicians and other health professionals to become involved in the education of future physicians. Programs include student rotation through both clinical and non-clinical areas of a hospital or clinic, observation and participation in the physician's office, and study of the functions of health related agencies and institutions in the community.

The stated objective of MECO is to effect a redistribution of physician manpower in the United States by exposing students, at an early point in their training, to the health care system of the community.

MECO was started in 1969 as a pilot project in Illinois. In that year 70 students were placed in 26 Illinois hospitals. Subsequently



the program has expanded to nearly 40 states in over 700 communities.

Participation in the project by hospitals and clinic groups is sought on a voluntary basis. Each such group, once it is designated, designs a program in conjunction with the student or students that are assigned to them. Each such sponsoring organization must have a practicing physician serving as the coordinator for the project. The participating student is furnished an educational stipend and room and board by the hospital or clinic. Each MECO program varies from four to ten weeks due to the different medical schools schedules and availability of students.

In preparation for next summer's MECO project in Oklahoma, hospitals and clinics throughout the state will be contacted and asked if they are interested in the program. Those responding will be furnished an information form to be filled out and returned to the state coordinating agency.

The project in Oklahoma is being coordinated by William D. Steen, PhD, Associate Dean of the OU School of Health and Alan S. Grubb, PhD, an instructor in the Department of Community Health.

Any clinic or hospital interested in the project may contact the OSMA's office in Oklahoma City. ☐

### **New OSMA Directory To Be Published**

The 1975 issue of the OSMA Medical Directory for Oklahoma is scheduled for publication before the end of the year.

The directory will contain two complete listings of all physicians practicing in Oklahoma, whether they are OSMA members or not.

The first roster will list all physicians alphabetically and will give their name, address, telephone number, year of birth, medical school, year of graduation from medical school, and their medical specialty. It will also show their membership status in the OSMA and whether or not they are retired.

The second complete roster of all Oklahoma physicians lists them alphabetically by city of practice. This list will also show their specialty, membership category and whether or not they are retired.

One copy of the directory will be sent free of charge to each physician listed in it. Additional copies will be available to physicians at a nominal charge. ☐

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## U S Navy Seeking Medical Officers

While all of the United States Armed Forces are in need of physicians, the US Navy seems to be the most aggressive in its recruiting.

A recent physician-recruiting release states, "Your medical responsibility will cover not only service men and women but their dependents of all ages — a patient population . . . prenatal to geriatric . . . that can provide the challenging need for satisfying professional advancement."

The navy does offer a short tour to physicians that provides an impressive list of benefits. They start out by pointing out that the navy physician doesn't have to worry about financial problems, the patient's ability to pay, or bookkeeping.

The navy offers residency programs in twenty-six specialty areas including endocrinology, plastic surgery and urology in nine major teaching hospitals. It has 149 rotating and straight internships in the nine teaching hospitals.

In addition to the usual specialties, the navy offers some unusual specialties including aerospace medicine, submarine medicine, nuclear medicine and cold weather medicine.

Vacation time for the navy physician amounts to thirty days a year with full pay and benefits. Other benefits include the reduced prices of commissaries and military exchanges, free medical, dental and legal aid, officers club and recreational facilities, including nominal or no charges for skiing, golf, sailboating, handball, etc.

To qualify for a naval medical tour a physician must be between 21 and 48 and a graduate of a medical school approved by the AMA. There are no restrictions on the applicants sex or marital status, although women with dependent children under 18 will be considered on a case by case basis.

Physicians or physicians-to-be may get more details from Chief Tom Bonavida, Medical Programs Recruiter, US Navy Recruiting District, 621 North Robinson, Oklahoma City, Oklahoma 73102.

Of course, no navy recruiting pitch would be complete without a reminder of worldwide travel. The news release points out that "in addition to the 28 major regional medical centers in the United States there are eight centers located in countries such as Spain, Italy, Guam, Japan, Cuba, Taipei, Phillip-

ines, and Puerto Rico. Smaller activities are located in Australia, Bermuda, Morocco, Sicily, Iceland, New Zealand, Midway and Okinawa." □

## CORRECTION

A September issue of "*OSMA Comment*" contained an incorrect statement under the heading "Medicare Legal Quirk."

In one paragraph it stated, "Medicare law specified that it can only pay the patient on an unassigned claim and that payments may not be made to any other person, including the legal representative of the enrollee's estate." This is **not** correct. Medicare can reimburse anyone who pays a Medicare enrollee's physicians' bill. This can include the legal representative of a deceased enrollee's estate, a member of the family, or a total stranger.

The information in the *OSMA Comment* was based on a statement made in the *Medicare News* published by Aetna Life and Casualty. *Medicare News* said, "If the physician does not agree to accept the reasonable charge as his full charge, Medicare payment on an unpaid bill may not be made to him or to any other person, including the legal representative of the enrollee's estate."

Medicare makes a distinction between a "paid" and "unpaid" bill. Until such time as the bill is paid by someone, Medicare does not have the right to reimburse anyone.

If a physician does agree to accept assignment on a deceased enrollee's bill, the assignment agreement can be signed after the death of the patient. It is not necessary, in such instances, to obtain the signature of the legal representative of the beneficiaries' estate. The physician only need note on the claim form that the patient is deceased.

It is still the physician's legal right to bill the estate of the deceased for his services. He does not have to accept assignment, unless he wishes to. After the estate pays the physician, it can recover the "reasonable charge" from Medicare. □

(Continued on page XXII)

## Mark Your Calendar NOW!

### OKLAHOMA MEDICAL SUMMIT '75

April 23rd-26th, 1975    Lincoln Plaza Forum  
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"What is AMA-ERF?" I was asked by a doctor and his wife. I was glad to tell that AMA-ERF (American Medical Association Education and Research Foundation) was organized in 1962 to seek financial support from the nation's physicians, medical societies, the Woman's Auxiliary to the American Medical Association, philanthropic organizations, business corporations and the general public. There are two fund-raising projects for AMA-ERF which the woman's auxiliary actively seeks funds for — the funds for medical school and the student loan guarantee fund.

More than \$58 million has been loaned to medical students, hospital interns and residents through the AMA-ERF student loan guarantee program. This fund helps needy students meet the staggering financial cost of their medical education. Each dollar in the fund puts another \$12.50 to work in loans made by a commercial bank.

As the country's demands for more physicians increases, the medical schools have had to expand their facilities. AMA-ERF funds are used by medical school deans to help pay for equipment, program, books, etc. for which budgeted funds are not available. *Total* contributions from Oklahoma physicians and members of the medical auxiliary amounted to \$20,027.40. Broken down, the University of Oklahoma School of Medicine received \$17,913.90; loan guarantee fund received \$1,313.50 and other funds \$800.00. These funds were raised by direct contributions from physicians, memorials, sale of Christmas cards, cook books, stationary, note pads and jewelry by members of the auxiliary. Several county auxiliaries had special fund raising parties. Oklahoma auxiliary received a national award for raising \$15.79 per capita. In addition to the state awards, Atoka-Bryan-

Coal Counties Auxiliary with a membership of less than 25 members won an achievement award with \$206.50 per capita. We are proud of both these awards and hope to better them next year as we know our Oklahoma medical school needs every dollar it can get.

It is now time to buy your personal Christmas cards. Why not contact your county auxiliary AMA-ERF chairman or me and see our beautiful cards. Remember that 40% of the cost of your cards will go to AMA-ERF.

Every doctor's wife should have one of the AMA-ERF Cook Books; they also make excellent gifts and so easy to get. These may be obtained through the County AMA-ERF Chairman or me. We also have note paper and memo pads at a small cost.

AMA-ERF hopes to have numbered, signed prints of the beautiful painting "After A Long Night" by Peter Hurd — presented by the auxiliary to the Oklahoma County Medical Society to the Cowboy Hall of Fame. Of course, there will be a limited number. I will soon have the cost, etc. If you would like to have one please contact me.

There are lovely \$10.00 AMA-ERF pure silk scarfs available and some Indian jewelry.

I would very much appreciate orders for a packet of three memorial, thank you, and appreciation cards. You will have the cards in your possession when needed to send to your friends. These are \$10.00.

In closing I want to thank each of you who has made a direct contribution or sent a memorial. Let's make 1974-75 the best year yet for AMA-ERF and Oklahoma medical school. *Mrs. E. Cotter (Dot) Murray, AMA-ERF Chairman, Auxiliary to the Oklahoma State Medical Association.* □



**Oklahoma Medical Summit '75**, the combined annual meetings of the OSMA, Oklahoma City Clinical Society, and the Oklahoma Academy of Family Physicians, is set for April 23rd-26th, 1975, in Oklahoma City's Lincoln Plaza Forum. Three nationally known physicians have agreed to serve as luncheon speakers during the meeting. Doctor Phil Thorek, Chicago, will speak on "The Physician and the Press." Doctor Malcolm Todd, AMA President, will be the Saturday luncheon speaker, while the President of the American Academy of Family Physicians, Doctor Herb Holden, will speak on Thursday.

**Incomplete Prescriptions** is a continuing problem for pharmacists. When the prescription is for a controlled dangerous substance the problem is compounded. The Justice Department has told all pharmacists, "In no case should a pharmacist accept a prescription for filling that does not bare the patient's name, the name of the drug prescribed or the prescribers signature." They go on to say that the pharmacist may fill in certain other information occasionally. All Oklahoma physicians are urged by the OSMA's Alcoholism and Drug Abuse Committee to fill in all the required information on a prescription, whether for a controlled dangerous substance or not.

**National Health Insurance** is having its ups and downs. President Ford called for enactment of NHI this year. Chairman Wilbur Mills of the House Ways and Means Committee, however, said that there was no consensus regarding the financing of NHI in this Congress and could not get such a bill through his own committee. Now, it appears that Senator Russell Long seems determined to push an NHI bill through the Senate by the time it recesses in mid-October for the elections. If he succeeds, and if Congress chooses to have a lame-duck session after the November elections, it is still possible that NHI could pass Congress this year. However, normally such bills are developed in the House of Representatives and then go to the Senate. Some congressional observers feel that Long's attempt to reverse the

procedure may meet with fatal resistance in the House of Representatives.

**Two Medical Programs** are being offered for Oklahoma physicians. On October 26th there will be a one-day seminar on "Arthritis for the Practitioner" at Lake Murray State Lodge near Ardmore. It is accepted for six credit hours by the Physicians Recognition Award of the AMA. Persons interested should contact the Oklahoma Rheumatism Society, 3313 Classen Boulevard, Oklahoma City, Oklahoma, 73118. The second program will be offered on November 8th and 9th in Oklahoma City's Lincoln Plaza Forum. "Women, Adolescents and Alcohol on the Rocks" is the title of the two-day meeting being sponsored by the Oklahoma City Clinical Society. This program is accepted for five prescribed study hours by the American Academy of Family Physicians. Additional information may be obtained from the society at 601 Northwest Expressway, Oklahoma City, Oklahoma, 73118. On the afternoon of November 9th, bus transportation will be provided from the hotel to Norman for the OU-Missouri Football Game.

**Non-Profit Hospitals** are no longer exempt from the National Labor Relations Act. The new law includes a provision for a 30-day fact finding period prior to the end of negotiations on a labor contract with hospital employees. The American Hospital Association had advocated a sixty-day cooling off period beginning at the end of contract negotiations

**Foreign Medical Graduates** should be accepted by all U.S. Training hospitals according to a report from the AMA's Committee on House Staff Affairs. The committee issued a report with 45 separate recommendations advocating the "elimination of double standards, discriminatory requirements and other pernicious policies. . ." The report comes at a time when there is almost a national movement to limit the acceptance of foreign medical graduates into any United States training program. There is a fear that the FMG's flocking to the United States are creating a foreign medical brain drain. The report will be forwarded to the AMA's Board of Trustees to be included in the board's report to the Clinical Convention of the AMA House of Delegates when it meets in Portland, Oregon, in December. □



## Tragic Sunset

I remember the first time I heard the expression, "The sun never sets on the British Empire." I was a child, and it was awesome to me to imagine the majestic expanse of an empire upon which the sun never set. Vicariously, I took pride in the power and the wealth of such a great nation allied with my own. I admired the strength and spirit of the British people, not one of whom I knew personally. Their courage and perseverance during the second world war was a source of inspiration to me and, when the late Winston Churchill declared it to be their finest hour, I cheered in agreement.

Although I have no enthusiasm for imperialism, something within me sickened when I heard, last month, of England's last-ditch efforts to prevent its own bankruptcy; the virtual socialization of its industry. I could not help but believe that the British national health program had played a major role in crippling a nation and bringing a people to its knees.

I am convinced that the incredible expense of their health program cost Britons their national defense establishments, encouraged their people to abandon the principle of self reliance and hastened the degradation of one of history's greatest governments.

A program designed to promote the health of its people has ironically afflicted a nation with a malignant illness. And it is dying.

In spite of this spectacular tragedy, our own nation, now the last great reservoir of man's freedoms, is standing in line, waiting to infect itself with the same malignancy. We ignore the lessons obvious in Denmark, Sweden, England and Canada; the only government that can survive a system of free health care is one that restricts the freedom of its citizens to the extent that every aspect of living and life must be under the absolute dominion of that government.

Faced with such a toll, no thinking, informed, free people could possibly agree to the trade. But here we stand, impatiently in line, unthinking, uninformed and soon to be un-free.

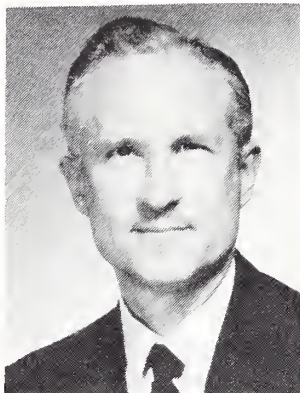
As I watch twilight settle over the British empire, I wonder if it was worth a free prescription, a free operation, a free set of dentures.

And I also wonder why we are so uninformed. I can remember when a British politician's sexual preferences were detailed on front pages and television screens for days. . .while the sun sank, slowly and so very quietly. MRJ



The Planning Committee for Summit '75 is hard at work preparing what I think will be the finest state medical meeting yet held. Doctor Buck Wagnon, Chairman, is heading a very able and devoted group to provide you an outstanding program next April. I am certain you will be delighted with the facilities which are the finest we have ever had. The entire Lincoln Plaza Convention Center in Oklahoma City will be ours for the meeting and I personally inspected all areas. The meeting rooms are carpeted, properly paneled and soundproofed. The theater where the banquet will be held is tiered in a curved fashion for good visibility and acoustics. Please mark your calendar for April 23rd to 26th inclusive and make certain to attend. As most of you by this time know, the hotel room appointments are excelled by none other in the state. Anyone who misses Summit '75 will truly miss a fine meeting held in deluxe facilities.

Meanwhile, your association will be holding meetings throughout the state to further the cause of the Health Sciences Center in Oklahoma City. This will be an informational slide presentation followed by a question and discussion period to inform not only the physicians of the state about the developments occurring at our Medical Center, but the lay public, civic leaders and legislators will also be invited to attend. Our Health Sciences Center needs the



support of the entire profession in order that its accreditation be assured and a new Tulsa Medical School be properly developed. After all, the Health Sciences Center is one of our state's greatest assets. When it is announced that the presentation will be made in your area, it will be hoped that you will encourage your civic leaders to attend. Federal aid to medical schools has diminished, so now we must get back to the good *old* American way of doing things for ourselves. Perhaps that is the best, after all.

Which leads me to another thought. I am wondering how many of our members realize just how much work their association and their Executive Directors, along with the OSMA staff secretaries actually perform in a month's time. There are some 30 committees working with great dependability and diligence, each headed by a chairman of outstanding ability. The volume of correspondence and telephone communication to the AMA, Washington, our State Capitol and regional legislators is gross.

We are indeed fortunate to have our three Executive Directors in the OSMA offices; these men work tirelessly for our benefit. Weekend meetings are the usual rather than the exception, yet they give pleasantly and unstintingly of their time. Their mature, objective counselling is a great benefit to the officers and committees. My compliments to them. I doubt that any other state medical association has their equal.

Remember the plan for Summit '75 next April — you cannot afford to miss it!

*J. L. Richardson, M.D.*



# The Physician and the Battered Child Syndrome in the United States and in Oklahoma

ROBERT M. WOODWORTH, DO

*Legal and administrative provisions for handling child abuse cases mushroomed with aroused public awareness, but the legal, punitive approach must now yield to prevention and treatment.*

The term "battered child syndrome" as a description of the clinical condition seen in young children who have received serious physical abuse from a caretaker, usually a parent, first surfaced in the literature in 1962.<sup>1</sup> Kempe,<sup>2,3</sup> its originator, recognized that the term was provocative, but felt that it was necessary to command the attention of pediatricians and the public. The interest in child abuse that was subsequently generated led, in only six years, to the passage of reporting laws in all 50 states.

Interest in and knowledge of the battered child syndrome have expanded rapidly in the past decade. Rapidly increasing incidence figures are partially a reflection of a higher index of suspicion, which results in more recognized

and reported cases. The distressingly high incidence also indicates that this problem continues to merit our attention and concern.

The purpose of this paper is, first, to present an overview of the problem of child abuse, especially as it concerns the physician. Incidence, etiology, guidelines for clinical diagnosis and management, and the physician's legal obligations in cases of suspected abuse will be reviewed. Secondly, how the problem of child abuse is handled at both the state and county level in Oklahoma will be described, as an illustration of the prevalence of the problem and of how legal and administrative provisions established for dealing with it operate in practice.

## OVERVIEW OF THE PROBLEM

### *Terminology*

Since 1962 many descriptive names for the battered child syndrome have been introduced. Fontana<sup>4</sup> believes that "the maltreatment syndrome" is more precise and descriptive because it encompasses the entire spectrum of neglect and abuse of children, from deprivation of clothing, food, shelter, and parental love to episodes of physical abuse. Silver<sup>5</sup> prefers "child abuse syndrome," which he defines as representing "a spectrum of clinical conditions: at one end of the spectrum would be the mal-

From the Department of Pediatrics, Children's Memorial Hospital, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.



## *The Physician* / WOODWORTH

nourished, starving, or 'failure to thrive' child; at the other end of the spectrum would be the child who has been severely traumatized physically." Silver intended his term to provide a more workable research definition — one that includes the physical, social, and emotional aspects of physical abuse. Caffey,<sup>6</sup> a noted pediatric radiologist, prefers "parent-infant traumatic stress (PITS) syndrome," which he feels is a fairer name because "PITS syndrome" accuses no one and because it suggests the emotional, social, and economic stresses that contribute to child abuse. The term "battered child" can be unjust before the guilt or innocence of the adult involved is legally established.

Although still others<sup>7 8</sup> have referred to the entity as "trauma X cases" and the "battered baby syndrome," the term "battered child syndrome" has received the most attention and probably will remain popular, despite the fact that it describes only one end of the spectrum of child abuse. The attention-getting and anger-provoking nature of the term contributes to its widespread adoption. It is interesting that Kempe and Helfer<sup>9</sup> even considered abandoning the term "battered child." They had considered dropping the phrase from the title of their book, *Helping the Battered Child and His Family*, but felt it would be premature to do so for two reasons: because complete understanding of the problems of abnormal child rearing was lacking, and because the need to provide a continuous impact still existed. One example of this continuing need is that, although all state legislatures have passed reporting laws, the majority have failed to appropriate funds sufficient either to implement these laws or to develop needed programs to help battered children and their families.

### *History*

The child abuse movement began in 1874 in

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*Robert M. Woodworth, DO, who graduated from the Chicago College of Osteopathic Medicine in 1970, limits his practice to his specialty of pediatrics. He is a member of the Sigma Sigma Phi, national osteopathic scholastic honorary society, the Beta Beta Beta, national biology honorary society and the American Public Health Association.*

New York City with the case of Mary Ellen,<sup>10</sup> a young girl severely abused by her parents. A group of church workers brought the family to court, but no legal action was taken because child abuse was not against the law. With the assistance of the Society for Prevention of Cruelty to Animals (because Mary Ellen was a member of the animal kingdom) the church group brought the family to court a second time, and this time the child was removed from her parents. The following year the Society for the Prevention of Cruelty to Children was founded.

In 1888 West,<sup>11</sup> describing a case of what probably would be recognized today as child abuse, called the condition "acute periosteal swelling in infancy." The condition improved spontaneously and could not be associated with any known disease. In 1946, Caffey<sup>12</sup> described six infants with chronic subdural hematomas and associated multiple fractures of the long bones. The fractures appeared to be traumatic in origin, although there was no history of trauma. Caffey noticed that metaphyseal defects occurred more frequently than defects of the bone shaft. The phenomenon of metaphyseal discontinuity was alluded to again in 1953 by Astley,<sup>13</sup> who presented six cases in which this condition occurred. He referred to it as "metaphyseal fragility of bone." In 1953, Silverman<sup>14</sup> described an entity that he called "unrecognized skeletal trauma in infants." He is generally credited with being the first to radiologically describe the battered child syndrome as we know it today, since his was the first report linking the roentgenologic evidence of metaphyseal fragmentation and cortical changes to traumatic episodes often missing from the history given by the parents.

Then in 1955, Woolley and Evans<sup>15</sup> observed that the syndromes described by Caffey, Astley, and Silverman were all variations of the same basic process of repeated trauma, whether or not a history of trauma was obtained. They also reported on 12 infants with multiple fractures. The home environments were unstable, with a high incidence of emotionally disturbed parents. Based on this and the nature of the multiple and repeated injuries, they concluded that the children were victims of repeated and willful parental physical abuse. Then when Kempe coined the phrase "battered child syndrome" at the 1961 annual American Academy of Pediatrics meeting, a large segment of the medical community was



dramatically informed of the problem. Since 1962, when Kempe *et al*<sup>1</sup> published their now classic report on the battered child syndrome, much has been published in both the medical literature and the lay press — an indication of current increased awareness of the problem, 100 years after the Mary Ellen case.

### *Incidence*

Accurate statistics, needed to determine the true incidence of child abuse, are scarce. There are several reasons for this:<sup>5</sup> (1) many definitions of child abuse exist, (2) not all abused children are taken to physicians or hospitals for medical attention, (3) some cases brought to medical attention go undiagnosed, and (4) some cases suspected by the physician are not reported.

Kempe *et al*,<sup>1</sup> in the first nationwide study of child abuse, surveyed 71 hospitals and 77 district attorneys, who reported a total of 749 children maltreated. Of these, 78 died and 114 suffered permanent brain damage. In only one-third of the cases reported by hospitals was a correct diagnosis followed up by legal action. In the group reported by the district attorneys, court action was initiated in 45% of the cases. An interesting sidelight is that one hospital, which reported no known cases of the battered child syndrome, just one year later reported 50 cases. This substantiates the importance of being aware of the problem.

Based on extrapolated data collected from California and Colorado, it has been estimated that 200,000 to 250,000 children annually in the United States require the help of protective services; 30,000 to 37,000 of them may have been severely injured.<sup>16</sup>

The American Humane Society estimated that, in 1969, approximately 10,000 cases of child abuse were reported. Twenty-five percent (2,600) of these cases were from New York City. Only 11 of the 2,600 were reported by physicians. Between the inception of a central registry in New York City in 1966 and 1971, the annual rate of reported cases increased a frightening 549%.<sup>16</sup>

It has been estimated that 700 children are killed every year by their parents or parent surrogates.<sup>2,17</sup> Fontana<sup>17</sup> reported that in New York City alone in 1972 there were 54 children reported to the Central Registry who died secondary to parental maltreatment. In the same year the city's Office of the Medical Examiner reported 48 child homicides. In addition, there

were 150 childhood deaths attributed to persons other than parents. This brings to a total of 252 the number of childhood deaths in New York City probably secondary to some form of child abuse. It was estimated that in 1973, 15,000 cases of child abuse would be reported to the New York City Central Registry.

Based on present statistics and their rate of increase, the National Center for the Prevention and Treatment of Child Abuse in Denver estimates that 60,000 cases of abuse and neglect will occur in 1974, and more in the years thereafter. The Center also estimates that over the next five years child abuse will cause 50,000 deaths and 300,000 children to have some permanent disability, either mental or physical. This would make child abuse the most common cause of death in childhood, outranking infectious disease, leukemia, and auto accidents.<sup>17</sup>

### *Etiology*

Why are some children physically injured by their parents or guardians? The answer is not simple. It involves not only rather complex psychiatric aspects but also certain at-risk factors affecting the child. Helfer and Kempe<sup>9</sup> and Helfer<sup>18</sup> believe that the abusive pattern consists of three basic components. First, a parent must have the *potential to abuse*. This potential is acquired over the years and is influenced by at least four factors:

(1) How were the parents themselves raised? Abusive parents usually had a poor upbringing themselves. One or both of them had an ineffectual "mothering imprint" during the first few years of childhood, and many were once battered children themselves. It is important, therefore, when evaluating a victim of child abuse, to learn about the child-rearing experiences of the parents.

(2) Are the parents "isolated" individuals, unable to use others for help when they feel pressured? Abusive parents have not developed an ability to use other people to help bail them out when they are having problems with their children. Related to such a parent's sense of isolation is his low self-image and sense of self-esteem.

(3) Do these individuals have a spouse who is so passive that he or she cannot give? Can one partner recognize when the other feels pressured and do something about it? Child abuse is a family affair, and it is of little use to ascertain which parent is inflicting the abuse. Even



if only one parent commits the abusive acts, the other, in some way, passively permits them.

(4) How do the parents view the child? They may have unrealistic expectations of him, which result from their own emotionally deprived and unloving childhoods. Through role reversal, they are attempting to gratify their dependency needs through their children.

The second component in the abusive pattern is *the child himself*. He has to be a particular kind of child. He is viewed as unusual or different by the parents. The child may be hyperactive, mentally retarded, or have a birth defect. Or he may have been the so-called provocative child, who as an infant was always irritable, had colic, was awake every hour or two, and was very demanding. Bishop<sup>19</sup> has suggested a list of at-risk babies: illegitimate children, premature infants, children with congenital malformations, twins, those conceived during a depressive illness in the mother, and children of frequently pregnant mothers with an excessive work load. Klein and Stern<sup>20</sup> and Stern<sup>21</sup> studied the problem of low birth weight as it relates to the battered child syndrome. Associated with instances of battering of low-birth-weight children were a history of lengthy infant-parent separations (necessitated by the infant's prolonged hospital stay after birth) and a strong history of deprivation in the mother's past.

The third component in the abusive pattern is the *crises* or *series of crises* that trigger the abusive act. These can be minor or major — a washing machine breaking down, a mother-in-law's visit, being drafted into military service, no heat or food, marital discord, or financial problems.

When this combination of events — parental potential to abuse, an at-risk child, and a crisis — occurs, child abuse can result.

Much has been written about the psychiatric aspect of child abuse and the abusive parent.<sup>22-28</sup> Abusive parents come from all walks of life and all socioeconomic backgrounds. The parents studied by Kempe<sup>2</sup> included lawyers, doctors, ministers, engineers, and army officers. The early assumption that abusive parents generally were of lower socioeconomic status has not been borne out. Of course, findings vary somewhat depending on the composition of the study group. Nearly all

racess, colors, religions, and levels of education and intelligence have been represented.

There is no all-encompassing psychiatric diagnosis that can describe the personalities and behavior of all battering parents. But these persons do share a common pattern of parent-child relationships, which are characterized by high parental demands on the child for gratification. Also, battering parents are overly vulnerable to criticism, which might lower their already low opinion of themselves. These emotional and behavioral characteristics are a reflection of the parents' childhood experiences and learning patterns. They were expected to perform well and gratify their own parents' dependency needs. The abusive parent's background was not the sort to foster a sense of self-esteem or a feeling of being loved that would act as a buffer and help carry him through periods of stress.<sup>29</sup>

According to Kempe,<sup>3</sup> in about five percent of battering families one parent has a psychosis that is frankly delusional or depressive in nature. Another five percent appear to be aggressive psychopaths. These individuals, mostly men, vent their anger by bashing children, wives, and friends indiscriminately. The remaining ninety percent are parents who have had serious problems in mothering.

Wright<sup>30</sup> coined the term "sick but slick syndrome" to describe, psychologically, a group of abusive parents that he studied. This phenomenon is characterized by a parent who outwardly appears normal, but who, in reality, is significantly disturbed. On the Minnesota Multiphasic Personality Inventory these individuals have high scores on the Psychotic Deviancy and Schizophrenia scales.

### *Diagnosis and Management*

Holter and Friedman,<sup>31</sup> who analyzed the charts of patients under six years of age who had visited an emergency room, discovered that about ten percent of children evaluated for traumatic injury had been physically abused. Therefore, the examining physician must consider the possibility of child abuse whenever evaluating a child with traumatic injury.

The maltreated child may present with various clinical manifestations, which may be associated with a history of failure to thrive. These include poor skin hygiene, multiple soft tissue injuries, irritability, a repressed personality, malnutrition, or other obvious signs of neglect (Fig 1). Fontana<sup>4</sup> has listed factors





Figure 1A



Figure 1B

Fig. 1 A & B: Evidence of abuse and neglect in a two-year-old boy. (A) Patient is obviously malnourished and has numerous scars on back. (B) Buttocks show evidence of previous soft tissue injuries. Patient was admitted *in extremis*, had CNS depression, pneumonia, seizures, anemia, hypocalcemia, hyponatremia, acidosis, proteinuria, fecal impaction, hypothermia, urinary retention, and no history of immunizations, and died on the day after admission.

which, if present, should strengthen the physician's suspicion of maltreatment: (1) age under three years, (2) poor general health, indicative of neglect, (3) characteristic distribution of fractures, (4) disproportionate soft tissue injury, (5) injuries in different stages of resolution, indicating different times of occurrence, (6) cause of recent trauma dubious, (7) suspicious family history, (8) history of similar episodes, and (9) no new lesions appearing while the child is hospitalized. Several extensive check lists for the diagnosis and detection of possible child abuse have been developed.<sup>32,33</sup> Table 1 presents one of the better ones.

The radiologic examination plays two major roles: it is a tool for case finding, and it subsequently can be useful as a guide to management.<sup>1</sup> Radiologic manifestations of the battered child syndrome are related

TABLE 1  
CHECK LIST FOR DETECTION  
OF POSSIBLE ABUSE  
IN CHILDHOOD INJURY\*

## THE CHILD

### History

1. An unexplained injury in a young child; especially a fracture in a child under two years of age
2. An accident history which does not adequately account for the child's injury
3. An accident history inconsistent with the developmental age of the child
4. History of a previous accident, easy bruising or frequent falling in a young child
5. X-ray evidence of unsuspected skeletal trauma

### Observations

1. Failure to thrive (height and/or weight in less than 3rd percentile)
2. Developmental retardation
3. Evidence of disturbed parent-child interaction; lack of attachment of child to mother and inappropriate maternal empathy

### Physical Examination

1. Skin and subcutaneous tissue — (a) Cradle cap, diaper rash, uncleanliness and other evidence of unconcern or unawareness of infant's needs; (b) Cigarette burns, bite marks, grab marks, belt lashes; (c) Ecchymoses, hematomas, abrasions and lacerations unusual for the child's developmental age; (d) Injury of external genitalia; (e) Marks on neck from strangling by hands or rope; (f) external ears traumatized by pinching, twisting, and pulling; (g) Unusual skin rashes which defy dermatologic diagnosis; (h) Burns, particularly of the soles of the feet and buttock.
2. Skeletal system — (a) Tenderness, swelling and limitation of motion of an extremity; (b) Periosteal thickening; (c) Deformities of long bones.
3. Head — (a) Cephalhematomas; (b) Biparietal bossing suggesting subdural hematomas; (c) Irregularities of contour resulting from skull fractures; (d) Signs of intracranial trauma.
4. Eyes—(a) Subconjunctival hemorrhages; (b) Traumatic cataracts; (c) Retinal hemorrhages; (d) Papilledema.
5. Ears—(a) Ruptured ear drums from blows to the head.
6. Face—(a) Periorbital ecchymoses; (b) Displaced nasal cartilages; (c) Bleeding from nasal septum; (d) Fractures of the mandible.
7. Mouth—(a) Lacerated frenulum of upper lip; (b) Loosened or missing teeth; (c) Burns of lip and tongue.
8. Chest—(a) Deformity of chest and limitation of motion due to fractured ribs; (b) Subcutaneous emphysema; (c) Hemothorax.
9. Abdomen—(a) Signs of peritoneal irritation from ruptured organs; (b) Abdominal masses from hematomas.



10. Central nervous system—(a) Lower motor neurone paralysis from spinal cord injury; (b) Upper motor neurone paralysis from intracranial injury; (c) Neurologic signs varying with location and extent of injury.

## THE FAMILY

### History

1. Documented history of previous neglect and/or abuse of the patient or another child.
2. A confession of abuse occurs rarely; it may be for the purpose of protecting someone else, frequently a guilty sibling.
3. Reports of witnessed abuse are not always reliable.

### Stress Factors

1. Frequent pregnancies with several children of pre-school age.
2. Prematurity.
3. Out-of-wedlock pregnancies.
4. Physically or psychologically absent fathers.
5. Economic stress.
6. Retardation of responsible caretakers.
7. History of alcohol or drug abuse. (The above may or may not be balanced by adequate support systems.)

### Special Factors

1. Autocratic child care practices, using physical punishment as a disciplinary measure.
2. Unrealistic expectation for the child to develop regularity in eating and sleeping patterns, early toilet training, and correct table manners.

\*from Gregg<sup>32</sup>



Figure 2A

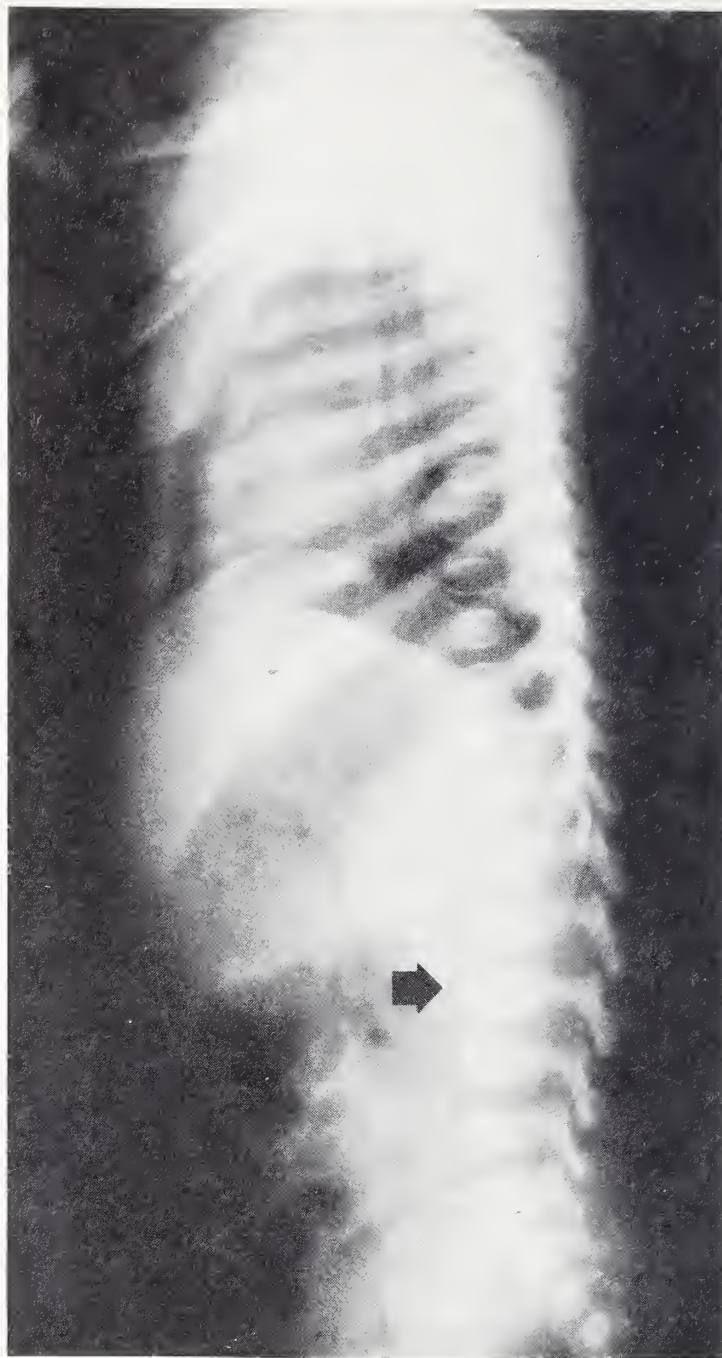


Figure 2B

Fig. 2 A & B: (A) Rib fractures at various stages of healing in a three-month-old girl. The fractures of the lower left ribs are the oldest, as evidenced by the degree of callus formation. Fractures of upper left and lower right ribs are intermediate in age. Fracture of lateral aspect of right sixth rib (arrow) is a fresh fracture with associated hematoma. (B) Old compression fracture of L3 (arrow) in same patient. Compression fractures of a lumbar vertebra are unusual in a child this young and should arouse suspicion of possible abuse.

primarily to repeated trauma to growing bones. After repeated trauma, roentgenograms will reveal body lesions at various stages of healing (Fig 2). One characteristic feature is metaphyseal fragmentation (Fig 3 and 4), which can be seen in the immediate post-traumatic period. Then with healing, squaring off of the end of the bone occurs. One may see





Fig. 3: Metaphyseal fracture of proximal end of humerus in an 11-month-old boy.

periosteal proliferation (traumatic involucrum). LoPresti<sup>34</sup> notes:

In small babies, there is a paucity of Sharpey's fibers and the periosteum is loosely attached to the shaft of the bone. In addition, the infantile periosteum is highly vascular and firmly anchored to the metaphyses by dense fibrous extensions. As a result, a small avulsion fracture of the metaphysis may produce a large subperiosteal hemorrhage. In approximately two weeks, as this hemorrhage is absorbed, the elevated periosteum lays down new bone and a bizarre cortical hyperostosis is produced.

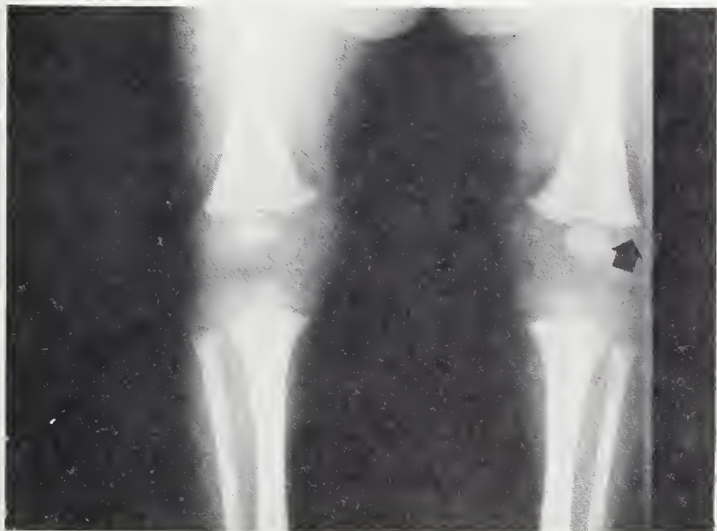


Fig. 4: Metaphyseal "corner" fracture of distal lateral left femur (arrow). Note normal configuration of distal lateral right femur. (Same patient as in Fig 2.)

This is why, even if x-ray examination shows no evidence of gross fracture, dislocation, or epiphyseal separation, one should obtain repeat roentgenograms in two to three weeks if abuse is suspected.

These radiologic changes rarely are confused with other conditions, but other causes should be considered in the differential diagnosis. These include: epiphyseal separation from accidental trauma, scurvy, syphilis, osteogenesis imperfecta, infantile cortical hyperostosis, osteoid osteoma, fatigue fractures, "little league elbow," neurogenic sensory deficit, and congenital indifference to pain.<sup>35</sup>

A rational approach to the management of child abuse quickly leads the physician far afield from traditional approaches to the practice of medicine. Because of the complexity of the problem, the assistance both of medical and other professional personnel and of community agencies is required. In addition to the pediatrician, psychiatrist, public health nurse, social worker, and/or child welfare worker, others involved may include the hospital administrator, juvenile court judge, school teacher, and police. The physician, though, is likely to be the *first* professional involved in an abuse case, since a majority of cases are reported by health facilities.<sup>36</sup> He has not only a legal obligation (which will be discussed later) but also a moral obligation to report cases of suspected abuse. If the physician is unwilling to accept this responsibility he should refer the case to someone who will, because without follow-up, 25% to 50% of abused children will either be dead or permanently injured within a year.<sup>35</sup>

What should be done when a child brought to the emergency room is suspected to be suffering from physical abuse? Because most emergency rooms are staffed by young physicians who are busy and too inexperienced to handle these emotionally charged situations, Helfer and Kempe<sup>33</sup> have suggested that emergency room physicians should: (1) consider the diagnosis of child abuse in all cases of traumatic injury in small children, (2) admit to the hospital *all* preschool (and most older) children in whom the diagnosis of child abuse is *suspected*, (3) rarely, if ever, accuse or confront the parents with the suggestion that their child has been physically abused, and (4) consult a pediatrician or social worker who has had considerable experience dealing with the multifaceted problems of child abuse.

Most parents will not resist the admission to



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the hospital; in fact, most will be relieved that something is being done. Remember that most of these parents do love their children. Admission of the child provides the needed time and environment to adequately evaluate both the child and the family. The decision to admit a child should rest solely on the suspicion of child abuse and not on the extent of physical injuries.

Three important principles should guide the physician dealing with parents.<sup>35</sup> First, he cannot be judgmental. He should not become angry with the parents, but should demonstrate his willingness to help. Second, he must realize that the parents are anxious to receive help. Third, he must keep the parents informed about everything that is happening to their child. These parents are overly suspicious and need to trust their physician. They need constant reassurance and support. Once the physician has convinced the parents that he is interested in helping them and has gained their trust, he must explain that state law requires him to report all children under his care who have suffered from non-accidental trauma. The parents should be told of the findings and the recommendations of the report, to whom the report is sent, and the potential results.

Once the child is admitted to the hospital, he should have a thorough evaluation that includes a complete physical examination, routine laboratory work, a skeletal survey, color photographs, and a coagulogram if he has any bruising. Ruling out any possible bleeding diathesis is important legally as well as medically. The physician responsible for the child's evaluation should make liberal use of consultants in radiology, neurosurgery, ophthalmology, orthopedics, and dermatology to help assess the injuries and define how and when they might have occurred.

A team approach with a hospital as the base of operations may be the most rational approach to child abuse cases. Helfer<sup>37</sup> suggests that every hospital or community where 25 or more cases are reported annually must develop a child abuse consultation team. At Colorado General Hospital in Denver, the child abuse team comprises four pediatricians (one a neurologist), two psychiatrists, two social workers (one works in the hospital and the other in the home), and a coordinator, who is a public health nurse.<sup>2</sup> While the hospitalized

child is being evaluated medically, the rest of the team focuses its attention on the parents and gathers data on which to base diagnosis, prognosis, and disposition of the case. This approach (medical center child abuse consultation team), the community-hospital treatment plan, and other approaches for protecting abused children and rehabilitating abusive parents are discussed in greater detail elsewhere.<sup>36, 38, 39</sup> Those discussions include interesting descriptions of the use of such methods as Parents Anonymous, a "hot line," crisis nurseries, and surrogate mothers.

What is the prognosis for a family in which child abuse has occurred? The large majority of children can be returned safely to the care of their parents after a brief separation or at least within eight months after treatment is initiated, but for five percent to ten percent parental rights are permanently terminated and the children are adopted.<sup>2, 3</sup> The younger the child and the more frequent and severe the injuries, the more permanent separation is considered.

Important to the management of child abuse is its prediction and, thereby, possible prevention. To this end two studies are now in progress. One project is being carried out in Aberdeen, Scotland,<sup>39</sup> probably the only city in the world to have a child advocate system. The city has about 3,000 deliveries per year. There are 65 health visitors who visit all families with children. These highly trained visitors ask a series of questions in an attempt to evaluate the home situation in order to predict at-risk families. Since there is only one hospital, all children who have accidents or fail to thrive are available for study. To date they have found that parents whose children have accidents, inflicted or otherwise, answer the questions differently than do parents whose children, matched for birthdate, had not had an accident. The other project is the development of a predictive questionnaire to identify potentially abusive parents.<sup>40</sup> The questionnaire is yet in its developmental stages and is useful only as a research tool.

Although identification of the battered child after the first episode of abuse is not optimal prevention, it may prevent much irreversible injury. It appears that severe permanent brain damage usually does not happen with the first episode of abuse.<sup>31, 41</sup> But without intervention, the first episode likely will lead to others. One short-term follow-up study of abused



children<sup>42</sup> (no long-term prospective studies have been done), for example, judged one-third of the subjects to have suffered from repeated maltreatment, even though some intervention occurred and some children were not returned to their own homes. Without attention, recurrence rates probably are even higher and repeated injury even more common.

Early identification of battered children, then, followed by intervention to prevent further, more serious abuse and to break the vicious cycle of today's battered children (those that survive) becoming tomorrow's battering parents, is the best we can do today. Prediction and total prevention are yet in their infancy, and the hospital or hospital-based child abuse team needs to act as child advocate.

### *Legal Aspects*

There are four broad areas of the law that relate to child abuse and neglect.<sup>43</sup> First are laws that mandate the reporting of *suspected* child abuse. Second are the traditional provisions of penal law that make persons guilty of abusive physical conduct towards a child subject to normal criminal penalties. Third are provisions that establish the procedure for civil processing of child abuse cases. Finally, there are the provisions of the law that establish protective services and designate the agencies to deal with the problem.

There are three basic community approaches to the problem of child abuse found today. In the protective services program, a social service representative works with the family and cooperates with the juvenile courts. If the child is in danger, a dependency hearing may be held and the child may be removed from the home. Major emphasis is on helping the family, not on penalizing the parents. In the second approach, a police department representative conducts the initial investigation. The uniform or police badge may make the parents defensive because of the implied punitive approach. Most authorities agree that criminal sanctions are largely ineffectual in preventing child abuse or even in protecting the child during the pendency of legal proceedings. Criminal courts have inadequate mechanisms or facilities for providing interim protection for a child or for undertaking effective parental rehabilitative measures. For these reasons there is a trend among states to place reporting laws and provisions for processing child abuse cases under the civil code rather than the penal code.

Only 14 states and the Virgin Islands place reporting laws under the criminal code.<sup>44</sup> In the third approach, both police and social service personnel investigate and make separate evaluations.

There is a growing belief that the best approach is some form of the social service approach, where the major goals are to protect the child and help the family use whatever community resources it needs. Protective services programs have various mechanisms or facilities at their disposal for interim protection of the child and rehabilitation of the parents.

Every state now has laws that mandate the reporting of all cases of suspected abuse. All but six designate the medical profession as the principal target group for reporting legislation,<sup>44</sup> although many states include other professionals, also. Twenty-nine states plus Guam and the Virgin Islands have a penalty clause in the reporting law, making it a misdemeanor to *not* report a suspected case of child abuse. All 50 states, the District of Columbia, Guam, and the Virgin Islands grant immunity from subsequent prosecution to the persons reporting suspected cases in good faith.<sup>44</sup>

The medical profession has expressed much concern over divulging confidential information revealed in the doctor-patient relationship. Therefore, 39 states, the District of Columbia, Guam, and the Virgin Islands have included a waiver provision in the reporting laws to free physicians from legal and ethical restrictions against revealing confidential information.<sup>44</sup>

To answer the question "Are child abuse laws enough?" Silver *et al*<sup>45</sup> in 1967 questioned physicians in the metropolitan Washington, DC area to assess their knowledge of the battered child syndrome, awareness of community procedures available, and willingness to report suspected cases. Findings suggested that physicians were not sufficiently aware of the battered child syndrome, nor were they adequately informed as to community procedures available for the management of the problem. About twenty-five percent of the 179 physicians who responded stated that they would not report a suspected case, even given legal protection. The investigators suggested several reasons for this reluctance: (1) difficulty in accepting the reality of willful abuse, (2) confusion regarding many basic terms and con-



cepts associated with the understanding and description of various degrees of neglect and abuse, and (3) lack of definition of the responsibility and limitations of the physician, child welfare agency or protective service, police, and juvenile or criminal court.

Seven years have passed since this study. Many state laws have been amended since 1967<sup>44</sup> and, hopefully, recent legislating of mandatory reporting laws, immunity from prosecution for persons reporting suspected cases, and release of physicians from legal and ethical sanctions against revealing confidential information will alter some physicians' reluctance to become involved. Up-to-date summaries of child abuse legislation<sup>44</sup> and other legal aspects of child abuse<sup>45,50</sup> can be found elsewhere.

CHILD ABUSE IN OKLAHOMA:  
THE LAW, STATISTICS, AND  
ADMINISTRATIVE PROCEDURES

At the State Level

Beginning in 1963, the Oklahoma State Legislature began passing laws directly related to child abuse.<sup>51</sup> Title 21 ("Crimes and Punishments"), Chapter 30, Section 843, *Beating or injuring children - Penalty*, became effective in April 1963 and provided for criminal punishment for abuse of anyone under 17 years of age. Then in March 1965 four important laws were passed: Section 845, *Public Policy - Protection of Children*, which made it state policy to protect children suffering from physical abuse; Section 846, *Mandatory reporting of physical abuse of children*, which defined who was to report, to whom, and the age range of children included, and made it unlawful not to report suspected abuse; Section 847, *Immunity from civil or criminal liability*, which exempted anyone reporting suspected child abuse in good faith from criminal or civil prosecution; and Section 848, *Admissibility of evidence*, which stated that evidence related to a child abuse case could not be excluded on the grounds that the matter is or may be the subject of a physician-patient privilege or similar privilege.<sup>51, 58-59</sup>

Section 846, regarding mandatory reporting, was amended in 1971 and 1972. The 1972 law had some important changes and additions<sup>51(p116)</sup>: (1) it was declared a misde-

TABLE 2  
SOURCE OF REFERRALS TO OKLAHOMA  
CENTRAL CHILD ABUSE REGISTRY\*

Source	Percentage of total referrals
Law enforcement agency .....	25
Relatives, including parents and self-referral .....	18
Day care centers, public and private social agencies .....	17
Schools .....	14
Private individuals .....	13
Hospitals, physicians, and nurses .....	11
Other .....	2
	100

\*For the 1-year period May 1, 1972 to April 30, 1973.

meanor to not report a suspected case; (2) age range was extended from under 17 to under 18 years of age; (3) not only physicians (including interns and residents) and registered nurses, but *anyone* who suspects child abuse, is directed to report it (thus making reporting of child abuse the obligation of the lay community also); (4) the county offices of the Department of Institutions, Social and Rehabilitative Services (DISRS) were designated as the agency to receive reports (the previous 1965 law had named several different agencies or individuals); and (5) the law directed DISRS to maintain a central registry.

Oklahoma is one of the few states that has computerized its Central Registry. By July 1974, local DISRS offices in all 77 counties in Oklahoma should be linked to the Central Registry, with display terminals for information input and retrieval by social work members of each county's staff.

From May 1, 1972 through April 30, 1973, 408 cases of suspected abuse or severe neglect were reported to the Central Child Abuse Registry.\* Table 2 lists the sources of the referrals. In slightly over seventy percent of the cases abuse and/or neglect was confirmed by a Protective Services worker. In 50% to 60% of confirmed cases, abuse was administered by beating with fists or instruments. Other types of abuse included sexual, cutting, burning or scalding, deliberate refusal of food or medical attention, drugs, and others. Of the severely

\*Statistics in this paragraph from Central Child Abuse Registry, Oklahoma Department of Institutions, Social and Rehabilitative Services



neglected children, some 60% were suffering from environmental neglect, *eg*, inadequate physical surroundings, care, or supervision. The remainder were considered neglected due to lack of medical attention, malnutrition, failure to thrive, or other causes. Of all abused and neglected children, two percent died. Slightly over 50% of all the children were under the age of six years; 51% were male. Almost 80% were white, just over 10% were black, slightly under 10% were Indian, and two percent were Mexican or of other racial origins. Slightly over 70% had been abused or neglected by their natural parents. A step-parent was the perpetrator in 15% of cases, other relatives in just over five percent, and unrelated persons in the remaining cases.

#### *At the County Level*

Cases of suspected child abuse or neglect in Oklahoma County are investigated by the Child Abuse and Child Neglect Units, two of four units in the Protective Services Section of the Oklahoma County Division of DISRS, the office legally charged with the responsibility of investigating reports. Calls received by this Section are classified into one of eight basic categories: physical abuse, sexual abuse, and environmental, medical, educational, physical, moral or emotional neglect. A record of calls has been kept since June 1972, when DISRS was legally designated as the agency to which reports should be made. Based on unofficial statistics, 1564 reports were received in the county between then and December 1973.<sup>52</sup> Comparison of the third quarters of 1972 and 1973 and of the fourth quarters of those years — the only time periods yet available for analysis — reveal a 135% and 80% increase in reported cases, respectively. Because of this dramatic increase in case load, the original Child Abuse Unit, composed of a supervisor and six social workers, was subdivided recently (Spring 1974) into an Abuse Unit and a Neglect Unit, each with a supervisor and six social workers, in an attempt to lighten each social worker's already heavy case load.

Most reports received by the Units come from one of two sources — the hospital or the general public, though some come from such other sources as school nurses. About 50% to 60% of telephone calls received from neighbors relate to neglect, whereas calls from hospitals are primarily concerned with abuse and failure to thrive.

When a call is received, a social worker is assigned to the case. During the subsequent home visit to the referred family, he introduces himself to the parents, informs them of the complaint, and explains the purpose of the Unit and the fact that all reports received must be investigated by state law. He stresses that the inquiry will be conducted as fairly as possible. Some parents are hostile, others are passive. Most inquire as to who made the referral, but they are informed that the information is confidential.

If it becomes obvious that the referral was not valid, a service case is established and placed on file. The social worker writes a narrative report and informs the original caller of the disposition of the case. No further action is taken. If, however, the social worker has some questions regarding the family situation, he adds the case to his clientele and follows the family closely. Finally, if it is obvious or if the social worker strongly suspects that a child has been maltreated, the parents are given the opportunity to take the child to a private physician or emergency room for physical examination and possible hospital admission. If the parents refuse, the Youth Bureau Division of the Police Department is called, and they obtain a court order to remove the child from the home. Fortunately, this rarely happens.

If the child is admitted to the hospital, either voluntarily by the parents or by a court order, a written report summarizing the admission history and physical examination is completed by the physician involved in the case and submitted to the Juvenile Court. Additional reports from the social worker, police, and psychologist also may be submitted to the Court. The Court decides whether to have an initial hearing based on these reports. At the dependency hearing, attorneys represent the parents, the child, and the state. The judge rules as to whether the child remains with the parents or is removed from the home. If the child returns home, the social worker will make home visits weekly or every other week.

When the judge rules in favor of temporary removal from the home, the child becomes a ward of the court and a suitable home is found either with relatives or foster parents who work closely with DISRS. During this period of separation the social worker attempts to develop a close working relationship with the parents, who hopefully will consider the worker a friend. Psychiatric help is suggested



## *The Physician* / WOODWORTH

if deemed appropriate, and the worker tries to correct the environmental problems that created the crisis and precipitated the abuse or neglect. A second hearing is usually held four to six weeks after initiation of the family's rehabilitation, and other, subsequent hearings are held periodically. The decision to return or not return the child to the home depends on the resolution of the family's problems.

The Abuse and Neglect Units maintain a 24-hour "hot line." A majority of the "hot line" calls are related to reporting, but gradually the number of calls from clients is increasing. A client is anyone who, because of stressful circumstances, feels he or she needs help.

Information about the existence and functioning of the Abuse and Neglect Units is disseminated through various means: (1) by referral from the Youth Police Bureau, school principals, hospital administrators, and family physicians and pediatricians, and (2) through speaking engagements by Unit personnel, which are given two to three times per week. The two units see their roles as related to four areas. First and foremost is the protection of the child; second is the rehabilitation of the family, to help develop family concepts and teach parents the art of mothercraft; third is maintaining the family unit, unless absolutely impractical; and fourth is educating the public.

### WHAT OF THE FUTURE?

The creation of "Centers for the Study of Abused and Neglected Children" has been a hope of many. In March 1969, a group of well-known experts held a seminar in Denver with the specific task of developing "criteria and recommendations for the establishment of centers for the study of abused and neglected children in large metropolitan areas."<sup>53</sup> It was felt that whether these centers became a reality depended upon the generosity of a philanthropic group or federal agency.

On February 1, 1974, President Nixon signed a bill establishing a four-year, \$85-million federal child abuse prevention program (Child Abuse Prevention and Treatment Act, P.L. 93-247:88). The law sets up a National Center for Child Abuse and Prevention in the Office of Human Development, Department of Health, Education and Welfare. The authorized funds will finance research and

demonstration programs and state aid for child abuse, prevention, and treatment programs, with state programs receiving from five percent to 20% of the total authorized funds (\$15 million for 1974, \$20 million for 1975, \$25 million each for 1976 and 1977).

The approach to the problem of child abuse seems to be going through the same evolutionary phases that characterized alcoholism treatment programs. Not too long ago, alcoholics who ran afoul of the law were placed in jail for a "drying out" period. Gradually it was realized that this legal approach neither solved nor prevented the problem. Groups such as Alcoholics Anonymous sprang up to offer emotional and psychological help. Today alcoholism is viewed as a disease, with psychological, social, financial, and medical implications. Most metropolitan areas have hospitals with detoxification and treatment units. Here the medical as well as psychiatric aspects of alcoholism can be treated.

The approach to the treatment of child abuse is now in a transition period. We are getting away from the legal, punitive approach, in favor of a more comprehensive method of dealing with the problem. Ideally, with the eventual establishment of a nationwide system of child abuse centers, the entire gamut of the battered child syndrome, including its social, psychological, and medical aspects, will receive consideration in treatment programs. In addition, further research into the *psychosocial* aspects of this "disease" will help us reduce its incidence and tragic consequences through preventive measures. □

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Dec. 11, Allergy/Immunology—James Wells, MD

Dec. 18, Current Concepts of Hematology—Walter H. Whitcomb, MD



## Socialized Medicine

SAM MCKEEL, MD

*In 1939 socialism was on the march throughout the world. Its advocates, in many instances, had leveled their sights on the practice of medicine as a "good place to start" in the United States. In that year Doctor Sam McKeel, in the private practice of medicine in Ada, Oklahoma, felt called upon to put his thoughts about "socialized" or "state" medicine on paper.*

Socialism is the nullification of individual ownership of property or funds.

The synonyms as given by Webster: Socialism, Nationalism, Nihilist, Anarchist, Communist, Bolshevik.

If we accept Webster as an authority, you may make your own application of Socialism to medicine and arrive at your own conclusion. However, we have heard so much of Socialized Medicine recently that we are compelled to conclude that it is a great question, and has some merit or it would die for lack of support.

One author, in discussing Socialized Medicine, defines it as any type of practice

which takes care of a group of people on a fixed contract basis. Another says, Socialized Medicine involves the remuneration of physicians and hospitals on a fixed basis out of tax funds. Another says, Socialized Medicine is the science and art of preventing and curing disease through collective effort with financial support of one or more social groups or governmental groups.

State Medicine, of which we have heard a great deal lately, is that form of Socialized Medicine which is supported and directed by local, state, or federal government.

The best excuse I can find for Socialized Medicine is the claim which I think is true, that some of the people are receiving inadequate medical care while many physicians were not as busy as they would like to have been in peace time, and it might be possible that Socialized Medicine will bring these two groups in contact, in such a way that both might benefit. If that be true, the question then would arise: Would that benefit outweigh the evil that would arise from the bad influence which Socialized Medicine would have on the citizenship of the country, or the medical profession, or both?

Let us take a look at some of the advantages which might be derived from Socialized Medicine.

If we have 100% Socialized Medicine, theoretically:



1. The indigent sick are assured of medical care equal to that of the wealthy person who is able to pay his bills.

2. When the head of the family retires at night or arises in the morning he has that feeling of security that if he or one of his loved ones should fall victim to accident or disease there will be adequate medical or surgical aid, promptly furnished, with no dread on his mind of a large debt accumulating which will embarrass him, or deprive him or his family of the necessities of life because of the indebtedness.

3. The expectant mother, regardless of the financial status of the family, will, theoretically, have the assurance that as she goes down into the valley of the shadow of death in travail, as one of her duties to perpetuate the human race, she will not have to suffer alone, but will be assured of the assistance of as good an accoucheur as her more fortunate and wealthy sister.

4. The unborn baby, who has no choice of whom its parents would be or whether it should have an existence or not, whether it was to be ushered into the world by accident or haphazard, will, theoretically, have the same scientific and able service as the more fortunate child of the wealthy parent.

5. Socialized Medicine will give the head of a family a more secure feeling when he is ill and his earning capacity is very low or nil.

He will have no worries about a large doctor bill accumulating, for he will know that the medical aid will be prompt, no embarrassing questions asked about his ability to pay, and, too, the attending physician will feel secure of his remunerations, although it may not be as much as he would like.

There may be other advantages that I have overlooked and that you are thinking of, but suffice to say that these I have enumerated are quite sufficient to cause many of my acquaintances to tell me, if asked the question: "Are you in favor of Socialized Medicine?" to answer, "yes." Then I ask the question "Are you a Socialist?" The answer is equally as often, "Hell, no," with emphasis on both "hell" and "no."

Now, let us look at some of what I think are disadvantages derived from Socialized Medicine:

1. It will increase the tax burden.

Since 1900 statistics show that the population of the United States has increased 50%.

The wealth of the country has increased

300%, while the tax burden has increased 1000%.

2. Socialism, as I stated in the outset, has been defined as nullification of individual ownership of property or funds.

Socialized Medicine is the nullification of individual rights to select one's family physician. This, I submit, is most undemocratic and un-American.

Under Socialized Medicine the father does not have the right to say who shall treat his sick wife or child.

3. Socialized Medicine nullifies the right of the expectant mother to say to her husband: "John, I know Dr. Jones' ability; I like him and have confidence in him and want him at my bedside when I bring forth to you a son whom we are going to call Junior and who shall be honored with the privilege of perpetuating your name. I am going down into the valley of the shadow of death, hazarding my life that we may rear a family."

4. Socialized Medicine nullifies the privilege of the unborn baby to be ushered into the world by a competent physician chosen by the parents, and says to that unborn baby, "You must take a chance, in your journey, on getting a competent or incompetent pilot."

5. It destroys the doctors' initiative, since it is supervised by political laymen unschooled in medical needs; and, it takes from him his right to say whether he will serve this family, or that family, and compels him to go and serve the family regardless of how repulsive that family may be to him, or he to the family. It compels him to go to the sick when he knows there is a lack of confidence in him. When confidence is lacking, it lowers or destroys the physician's influence with his patient, thereby depriving him of one of his most potent assets, that is, the power of suggestion.

Throughout all ages, from primitive man to the world of modern culture and science, fear of pain has been slightly less than fear of death.

Obviously, the most important reasons for which people seek the help of the physician is fear, and the most gratifying task that the medical man can perform for his patient who has confidence in him is suggestion.

And God knows if there ever will be an unpleasant task to perform, it will be for a doctor to have to stand by a bedside and hear the rattle of the dying man's last breath and see the look of horror in the stare that faces death, and hear the dying man say "Oh, if we could have



and hear the dying man say "Oh, if we could have gotten a doctor in whom we had confidence, I would have gotten well." If this be unpleasant for the doctor, imagine the feelings of the family.

6. It lowers the standard of medicine. That is the history of every country that has had Socialized Medicine. Today, I know of but one great nation that has 100% Socialized Medicine and that is Russia; and Russia is not known for any of her medical attainments. Let us pray we never emulate Russia.

Germany, that nation that once led the world in medical accomplishments, has gradually declined since 1873 when Bismarck forced partial Socialized Medicine on those people.

Great Britain, in 1911, under Lloyd George's leadership, inaugurated the Panel System, which is a form of Socialized Medicine, and that has proven very unsatisfactory, both to the medical profession and to the people in general.

Here in the United States, until just recently, we have been able to keep our medical profession independent of politics and other outside influences that tend to handicap us, and we have gradually forged forward until today the United States is the medical capital of the world, just as Germany was before Bismarck's time.

But now we have a Bismarck in the person of Senator Robert F. Wagner, who was born in Germany in 1877, four years after Bismarck started his medical reform, and he, no doubt, became imbued with the socialistic tendencies of those people and brought their ideas to the United States and is now foisting them on the American People through his National Health Bill, Maternal and Child Health Service, Social Security Bill, and other bills which we fear are forerunners of efficient medical destruction.

We would be the last on earth to condemn a man because of his birthplace, or his youthful environment, but we do resent with all our being the man that comes to our democratic government by substituting socialism, regardless of its disguise or nomenclature.

Socialized Medicine will give each individual a free hand to call on the medical profession at any hour, regardless of whether the person is ill or not, with no thought of expense to himself or inconvenience to the doctor.

It will have a tendency to encourage malingering and will, on the other hand, encourage the doctor to feign sickness as an excuse for not filling a call — or to go fishing and have his wife lie for him by saying he is too sick to fill the call.

Under our present form of medical practice the doctor is more efficient today than ever before in the history of the world. The medical schools in the US have attained the highest standard in the history of any nation, and, therefore, through efforts of the medical profession, the average life in the US exceeds that of any other nation in the world by several years.

Our general death rate has been steadily declining: the death rates from tuberculosis, diphtheria, and other diseases have been greatly reduced.

The medical profession lays no claim to perfection, but we do claim if allowed to pursue the cause of organized medicine unhampered and unhindered, greater achievements are yet to come.

If Socialized Medicine is a panacea for the evils growing out of the present inefficient medical service, why not expand this socialistic idea until all the ills of the human race may be cured?

Is it not a fact that no one can have a healthy body if underfed and undernourished? Then, let us socialize the grocery stores and let every man, woman and child go without money, to the grocery store and help themselves to the best food there is, as a precaution against illness, which will lessen the necessity for medical service.

And then let us take another step, for we know that no human body can enjoy health if it is uncomfortably clad, so let us socialize the clothing stores. Let every man, woman and child go to the clothing store and select such clothes as will keep them comfortable and thereby lessen the need for medical service.

Then, let's take another step. No one can have health if his body is unclean, so let's establish bath houses, with hot water, throughout the town and country, furnish them with attendants, so that everyone can keep his body clean, and thereby cut down the need for medical service.

No person can be 100% well if unhappy, so after he has become accustomed to all the good food he needs, all the clothes he needs and his constantly clean body, he will be unhappy if he



is not well groomed so let's socialize the barber and beauty shops and see that every man, woman and child is kept well groomed and give him his hair cuts, shave and hair dressings as often as desired.

And, then let's take the gold of the world, which is now hoarded in a secure place in Kentucky, and pave the streets with gold.

Then, let's take the small percentage of energetic people, who are never happy unless

at work earning their own support, who have built this country and put them on oyster farms, raising pearl-producing oysters and building pearly gates, thus establishing a heaven on earth.

This regime will take care of all of our citizenship, except the lawyers and preachers. Since there will be no incentive for anyone to do wrong, there would be nothing for the members of either of these professions left, except to join the happy throng of the idle. □

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## News From The Oklahoma State Department of Health

### Tetanus Prophylaxis in Wound Management

The physician is often faced with questions concerning tetanus prophylaxis in patients with wounds.

Available evidence shows that complete primary immunization with tetanus toxoid provides long-lasting protection. Also, protective antitoxin levels develop rapidly in response to booster doses in persons who have previously received at least two doses of toxoid. Therefore, passive protection (TI or equine origin antitoxin) is considered only in persons having had less than two previous doses of tox-

oid or when the wound has been unattended for more than 24 hours.

The following table is suggested as a guide to handling active and passive tetanus prophylaxis in wound care:

#### GUIDE TO TETANUS PROPHYLAXIS IN WOUND MANAGEMENT

History of Tetanus Immunization (Doses)	Clean, Minor Wounds		All Other Wounds	
	Td	TIG	Td	TIG
Uncertain	Yes	No	Yes	Yes
0-1	Yes	No	Yes	Yes
2	Yes	No	Yes	No <sup>1</sup>
3 or more	No <sup>2</sup>	No	No <sup>3</sup>	No

<sup>1</sup> Unless wound more than 24 hours old.

<sup>2</sup> Unless more than 10 years since last dose.

<sup>3</sup> Unless more than 5 years since last dose.

Reference: U.S. Public Health Service Advisory Committee on Immunization Practices.

### COMMUNICABLE DISEASES IN OKLAHOMA FOR SEPTEMBER, 1974

DISEASE	September 1974	September 1973	August 1974	Total To Date	
				1974	1973
Amebiasis	2	1	6	22	26
Brucellosis	2	—	1	7	4
Chickenpox	10	10	6	816	1312
Encephalitis, Infectious	3	7	2	40	96
Gonorrhea (Use Form ODH-228)	960	895	962	8343	8230
Hepatitis, A, B, Unspecified	58	107	60	771	837
Leptospirosis	—	—	—	1	—
Malaria	—	—	—	3	2
Meningococcal Infections	—	3	1	15	31
Meningitis, Aseptic	10	16	8	55	98
Mumps	3	13	11	372	445
Rabies in Animals	14	8	15	126	145
Rheumatic Fever	2	2	2	11	14
Rocky Mountain Spotted Fever	5	4	7	58	72
Rubella	3	1	8	55	180
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	2	2	1	27	55
Salmonellosis	31	26	31	203	201
Shigellosis	30	13	20	138	162
Syphilis, Infectious (Use Form ODH-228)	16	15	6	109	135
Tetanus	—	1	1	1	4
Tuberculosis, New Active	11	31	25	227	240
Tularemia	1	—	3	14	19
Typhoid Fever	—	—	1	2	2
Whooping Cough	2	1	2	16	21

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## OSMA Seeks Opposition To National Health Policy Act

Proposed legislation entitled "National Health Policy, Planning and Resources Development Act of 1974," is being opposed by the OSMA. In a letter to all members of the Oklahoma Congressional Delegation, Jack L. Richardson, MD, Association President, asked that they vote against the passage of HR 16204.

President Richardson told the congressional delegation, "the purpose of this letter is to express the strong objections of a medical profession against legislation of this type."

The purpose of the bill would be to supplant the existing comprehensive health planning program, regional medical program, and Hill Burton program with a single agency having stronger federal controls and expanded powers over both the health care industry and state and local governments. It would call for the creation of a rigidly — structured system to be overseen by the Secretary of Health, Education and Welfare. He would dominate a national council for health policy, state health planning and development agencies and regional health systems agencies. The entire structure would be financed and operated according to federal directives.

"State legislatures," Richardson said, "would be forced to adopt state regulatory laws as prescribed by HR 16204, and these laws would most likely result in the regulation of all health services under a public utility concept."

The remainder of the Association President's letter is as follows:

"A gross misuse of the popular 'consumerism' fad is embodied throughout the three levels of control which HR 16204 invites upon the health care industry. For example, Health Systems Agencies, those groups which will plan a development health services in regions encompassing populations of 500,000 or more people, will be governed by consumer dominated boards. The definition of consumers reached a new dimension of sophistication . . . they will be representative of a 'social economic, linguistic and racial populations.'

This united nations type of government may not generate the kind of expert leadership necessary to deal with the complexities surrounding the health care industry. The inability to speak English is not a qualification for health planning.

" 'Providers' will be given a minority roll in health planning and development, and to make matters worse, the federal definition of 'providers' could result in little or no physician input. While physicians could be included on the HFA governing board, so could all other health professionals . . . in fact, anyone who derives more than 10% of his income from the health care industry is graduated from a 'consumer' to a 'provider' under the terms of HR 16204. Today, under a similar arrangement used by the Comprehensive Health Planning Agencies, many regional governing boards have no physician representation.

"Converting health professionals and health care institutions into public utilities under this program will not come cheaply. The bill would provide \$4,000,000 a year to support a new health bureaucracy in Oklahoma.

"Moreover, when you consider that health professionals will be largely dealt out of the planning process — just as they have been largely dealt out of the existing Comprehensive Health Planning agencies — one can legitimately question the quality and practicality of any health planning which may come from a consumer group. The problem of improving accessibility to health care by redistributing health manpower to serve shortage areas is perplexing even to expert health professionals, especially at a time when there is a shortage of trained professionals and a continuing decline in the populations of most rural communities.

"Here is a \$4,000,000 tip for the Secretary of HEW and those members of Congress who are sponsoring H.R. 16204. Health care in the rural areas will have to be supplied on a regionalized basis . . . by developing and expanding some of the existing medical com-



munities (county seats) to serve larger peripheral areas . . . by using Physicians Assistants to hold sick call in the smaller communities and to channel patients to the higher levels of care available at the nearest regional medical center, and perhaps on to major metropolitan medical centers in the state as the patient's condition may warrant . . . by developing health education courses and first aid training programs for the small communities . . . by vast improvements in emergency medical care systems (ambulance services, better trained ambulance personnel, etc.).

"With personnel shortages as they are today and as they will be for at least the next ten years, there is simply no other way to plan anything better for the underserved areas of Oklahoma. Our association already knows this as a result of studies we have financed; the Oklahoma Regional Medical Program knows this and has undertaken efforts to bolster outlying medical centers to improve their capacities to undertake greater responsibilities; and the University of Oklahoma College of Medicine knows this and is decentralizing its family practice training program to accommodate the regional health centers around the state.

"We will wager that the consumer groups who would operate Health System Agencies under HR 16204 would eventually develop the same concept . . . over a period of years, and after spending millions of tax dollars.

"We could lose our bet, however. The track record of federal health planners is not good. For example, the CHP concept which would generally be endorsed and expanded under HR 16204, has not produced any beneficial health planning results to our knowledge in the eight years it has operated. At the very best, it can be said that federally-funded CHP activities to date (since 1966) have not demonstrated a level of performance adequate to justify an extension and expansion of the magnitude prescribed in HR 16204.

"All of us would like to see improved health services brought to our citizens who live in sparsely-settled areas, or in certain parts of our metropolitan centers. Experimentation should be carried out to explore concepts which have already been developed. Federal funds could be judiciously used to establish pilot projects, conducted through grants to professional groups,

and to perhaps develop a model system which, if successful, could be extended to other areas. This approach would be much better than a wholesale leap into a new nationwide federal bureaucracy managed by well-meaning but ill informed consumer groups.

"If this alternate concept of professional experimentation cannot be achieved, it would still be wise to defeat HR 16204 at this time and to simply extend the funding of the Regional Medical Program, the CHP program and the Hill-Burton program as separate entities until such time as something more sensible than HR 16204 can be developed by Congress.

"As President of the Oklahoma State Medical Association, I am responsible to a constituency of some 2,500 medical doctors, and despite a busy orthopedic practice of my own, I feel that I am attuned to the attitudes, concerns and frustrations of my colleagues.

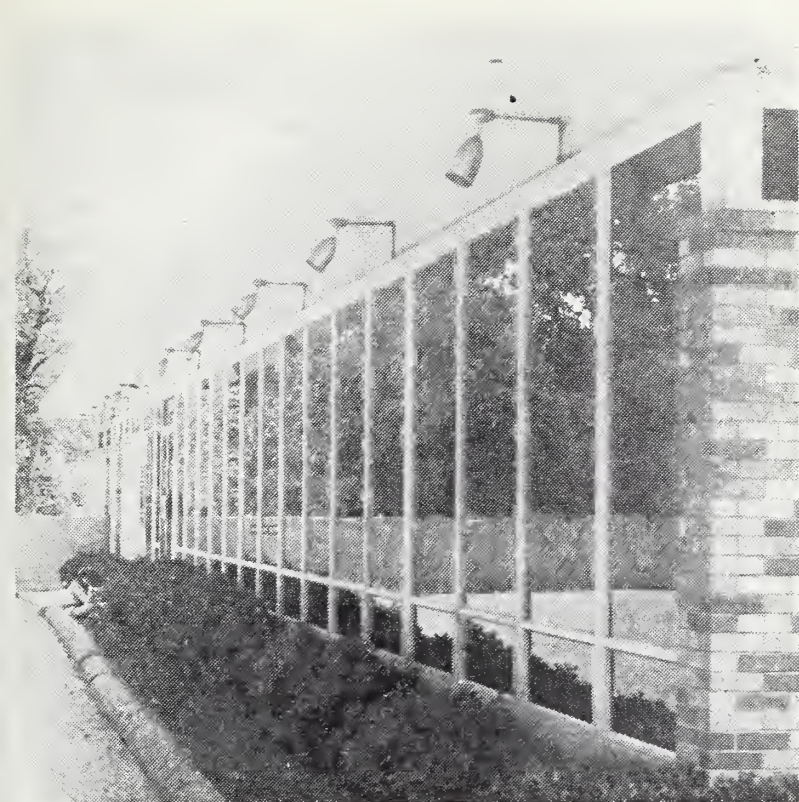
"We do not understand how we can work so hard in our profession and, according to polls, achieve the highest public esteem rating in the nation, and then to be subjected to federal legislation such as PSRO (PL 92-603), HR 16204 and S 3585 (to make indentured federal servants out of all medical students, to require federal licensure of physicians, to federally control all residency training programs, etc.). In the face of no viable alternative, our association has reluctantly decided at this time to participate in the regulatory PSRO program . . . at a cost to the taxpayers of \$2,000,000 a year. Now, through HR 16204, we see another \$4,000,000 of federal money directed toward our regulation.

"Do you think we deserve \$6,000,000 a year in federal regulation? Do you think this expenditure will make us that much better doctors, or make us work harder? Do you honestly feel that HR 16204 will result in some grand plan from which the public will receive great rewards?

"I don't think you have these great expectations of HR 16204. I am hopeful that you will agree with me that legislation like HR 16204, S 3585 and PL 92-603 will do nothing spectacular for the American people and will very likely cause a decline in the industry . . . in the professionalism . . . and in the dedication now possessed by the vast majority of American physicians.

"The physicians of Oklahoma request that you cast a negative vote on HR 16204." □





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## Health Sciences Center Recommendations Publicized

A statewide informational campaign being waged by the Oklahoma State Medical Association is resulting in public interest in the Oklahoma University Health Sciences Center in Oklahoma City.

Representatives from the center, the OSMA's Medical Center Liaison Committee, and an OSMA officer have now visited most of the state's major cities with a 22 minute audio-visual slide presentation entitled, "Medical Education in Oklahoma . . . Who Cares?". The presentation outlines the OSMA's recommendations to the multitude of problems being faced by OUHSC.

The presentation begins by recognizing that OUHSC has a new fiscal management system that should give the center the capacity of making quick responses to future financial emergencies.

A new faculty practice plan at the center permits faculty members to engage in private practice with the provision that a portion of their earned income beyond their salary contract goes back into OUHSC. In the past, this has amounted to as much as 15% of the College of Medicine's total budget.

The first "hard" recommendation made by the OSMA presentation is that all educational costs incurred by the University Hospital should be paid by the Health Sciences Center as an educational expense. Approximately 28% of the hospital's total budget of \$18,000,000 is educational in nature.

Another recommendation was that the leadership of the Oklahoma Legislature should immediately convene a special "indigent care study group" comprised of private citizens and public officials with special knowledge to consider new methods of dealing with the charity care question. For many years, the University Hospital has absorbed an abnormally high number of medically indigent patients. These are patients who are not covered by some type of medical insurance, either government or private, and cannot afford to pay for their own medical care.

Another problem with University Hospital is one of diseconomy of size. Everett Tower was envisioned as the start of a thousand-bed hospital, but so far only 200 beds have been built.

However, the Tower contains all of the service facilities for the full one-thousand beds. The University Hospital's Board of Trustees is urged to develop innovative ways to share these services with other nearby institutions, such as Children's Hospital, Veteran's Hospital, the new Presbyterian Hospital and the Oklahoma Medical Research Foundation. This will allow Everett Tower's core facilities to be used in a more economical manner.

Surveys conducted throughout the United States show that there is a very high correlation between the place where a young physician takes his residency training and where he ultimately goes into practice. The OSMA is recommending that the number of first-year residency programs in Oklahoma should be increased to match the number of graduates from the College of Medicine. This will be about 200 per year by 1979. At the present time there are fewer than 90 residency physicians in the State of Oklahoma.

The cost of all residency programs should be partially born by the state through higher education dollars. At the present time, residency physicians are being paid for by private hospitals, which, in turn, must pass the cost on to paying patients. It is proposed that the state assume 50% of residency costs in order to encourage a major expansion of residency physicians.

Specific emphasis should be placed on increasing the number of family practice residencies. A program has already been proposed by the College of Medicine, and endorsed by the OSMA, which would call for increasing by 400% the number of such residencies in the state. The program would establish residency physicians in such cities as Enid, Ada, Lawton, Ardmore, McAlester, Muskogee, and other cities such as Bartlesville, Chickasha, and Stillwater, which meet the established criteria. This "satellite plan" would create a total of 47 family practice residencies in Oklahoma.

The final recommendation made in the slide presentation is that the Oklahoma Legislature should reevaluate its appropriations to higher education and ultimately the Health Sciences Center. While the OSMA does not recommend a specific budget, the presentation states, ". . . we do recommend that state support be granted on the basis of potential rather than problems . . . on the basis of true need. With every new classroom completed, with every new student added, costs increase and



these costs must be recognized and funded if we are to achieve our goal of providing first class health care for the people of Oklahoma."

All Oklahoma physicians are asked by the OSMA Medical Center Liaison Committee to call these recommendations to the attention of their local legislator. The presentation ends by stating, "We believe there is no higher priority than the health of our people. That's why we urge your concern, your understanding and your support of these programs and solutions. We believe the Health Sciences Center is one of the state's greatest assets. Its major problems are history. Its foundation for future service to people is sound. Its needs for future support are critical." □

## Medicare Deductibles Increased Again

Medicare beneficiaries will face higher deductibles in 1975. Beginning January 1st, a person who is admitted to the hospital under Medicare will be responsible for the first \$92.00 of his hospital bill.

The Medicare law requires that the Secretary of HEW evaluate the deductibles each year. The present deductible of \$84.00 will re-

main in effect for Medicare hospital admission during the remainder of 1974.

When the Medicare program began in 1966 the deductible was \$40.00. At the 1975 rate of \$92.00, the new deductible is 230% higher than the original 1966 level.

According to a report in the Commerce Clearing House publication *Medicare and Medicaid Guide*, at the present time, the average hospital stay under Medicare is about eleven and one-half days, at a cost of over \$1,000. That reports goes on to summarize the new deductibles by stating, "when a Medicaid beneficiary has a hospital stay of more than 60 days, he will have to pay \$23.00 a day for the 61st through the 90th days, up from the present \$21.00 per day. If he has a post-hospital stay of over 20 days in a skilled nursing facility, he will pay \$11.50 per day toward the cost of the 21st day through the 100th day, up from the present \$10.50 per day."

Immediate reaction came from Capitol Hill when the \$92.00 deductible was announced. Senator Abraham Ribicoff, a member of the Senate Finance Committee, promptly introduced a bill that would freeze the deductible at the \$84.00 level through 1975. His bill was immediately co-sponsored by 32 Senators. □



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## South America Travel-Medical Workshop Ready

A fourteen-day air-sea cruise along "the sunshine coast of South America" is being sponsored by the OSMA for a limited number of its members and families. Reservations are now being accepted on a first come, first served basis for the January 28th departure from Oklahoma City and Tulsa.

A combination of exciting ports and comprehensive professional workshops on "Emergencies in Medical Practice" will add to the pleasure of traveling with colleagues and friends. The tour will fly, via privately chartered Trans International Airlines "stretch" DC-8 jet, directly to Montevideo, Uruguay. There the Oklahomans will board the luxury cruise liner Stella Oceanis. Ports of call for the next thirteen days will include some of the most exciting cities in the Western world: Buenos Aires, Mar del Plata, Salvador, Vitoria, Rio de Janeiro, Sal Paulo and Montevideo. Visits to Brazil's ultramodern capital, Brasilia, and the great Iguassu Falls which join the borders of Argentina, Brazil and Paraguay, are among the optional excursions available.

The South American cruise is priced from \$995 and includes round trip jet transportation, deluxe accommodations on the sunline cruise ship Stella Oceanis, and all meals of the finest international cuisine. Baggage allowance is a generous 70 pounds. An experienced escort will accompany the tour throughout the trip, and aboard ship a cruise director and staff will assist both on ship and ashore.

The tour will return to Oklahoma on February 10th.

The workshop on "Emergencies in Medical Practice" has been planned and organized by Seminars and Symposia, Incorporated. A distinguished faculty will conduct 28 hours of classes, all scheduled to give the faculty members and the participants ample time to develop the theme and not conflict with the enjoyment of visiting the fascinating places on the cruise. In addition to the accompanying faculty, arrangements have been made with local professors of medicine to conduct several workshops in the ports of call.

Persons interested in the tour should contact the OSMA office in Oklahoma City immediately. □

## Study Shows Government Performance Below Par

According to a recent study by the government accounting office of the United States Congress, the federal government's performance in handling Medicare claims falls far below that of private carriers.

The GAO, watchdog of the federal government reporting directly to Congress, plans to file a report with the House Ways and Means Committee in the near future. A summary of the report was printed by *NHI Reports*, a newsletter devoted to national health insurance.

The GAO evaluated the comparison of performance between the direct dealing reimbursement branch, known as DDB of the Social Security Administration with private intermediaries including two Blue Cross plans in Baltimore and Chicago, Mutual of Ohio, and Travelers.

In summary, the report indicated that the DDB had the highest cost, the lowest productivity, highest processing time and the lowest number of cost report audits and settlements completed.

Since the Social Security Administration does not file quarterly and annual financial reports, which the government requires of private intermediaries, the GAO found it difficult to provide comparative cost information. Therefore, the report had to make assumptions regarding costs paralleling the same information from private intermediaries.

The two Blue Cross plans came out with the highest performance ratings, with the DDB's performance only half as good as the Blue's. □

## Health Care Costs Small Part of Inflation

President Ford's long heralded summit economic conference produced relatively little talk about health care costs and inflation, despite the fact the HEW's Secretary Weinberger had "pointed with alarm" to that portion of the economy.

A presummit session on health and the economy apparently was designed to support Weinberger's contentions. However, most of the summit conferees showed to center their attention on other portions of the economy.

AMA President Malcolm C. Todd, a delegate to the conference, said that he agreed with the President with respect to avoiding controls at this time. "Every American, every physi-



cian, has the duty to assist in solving the number one problem of the Nation — inflation," Todd said. He went on to note that the AMA had repeatedly stressed the need for restraint by physicians in avoiding unjustifiable charges in fee increases.

The presummit session on health was presented by Michael Subkoff, professor of health economics at Meharry Medical College and Vanderbilt University. He stated that "it is generally recognized that the health sector is both a hostage and a cause of inflation." According to the professor, the presummit meeting had determined certain "structural defects" in the health care delivery system which included:

"Fee for service payment for physicians and cost-plus reimbursement for hospitals . . . encourages cost growth.

"First dollar insurance coverage reduces cost consciousness by consumers.

"Consumers lack knowledge to become aggressive informed purchasers of health care."

Doctor Todd criticized the administration for "singling out" health by "annualizing" monthly consumer price index levels. The practice of projecting the yearly increases on the basis of what happens during one month or several months has been followed only on "health" by the HEW department so as to bolster its contention that the health segment should be isolated for controls.

The AMA president noted that in the past three years, physicians' fees have risen 17.6% compared with 22.9% for the economy as a whole and, for example, 32.9% for legal charges.

The AMA president did make specific recommendations for steps to curb medical costs. These included preadmission testing, expansion of ambulatory care services, earlier discharges from hospitals, avoidance of unnecessary hospitalization, and decreasing the cost of malpractice insurance.

In addition, Doctor Todd said, "perhaps physicians should attempt voluntarily to guide their fee-setting decisions by tying their charges to the consumer price index levels and not exceeding them."

HEW's Secretary Weinberger's attempt to annualize the monthly consumer price index brought responses from numerous people, notably the President of the California Medical Association.

Stanley A. Moore, MD, CMA president, said that the consumer price index showed physicians' fees rose a total of 4.4% during the first three months following the end of wage price controls April 30th. "Even if these three months of experience could be annualized," he said, "the increase would amount to 17.6%, not the 19.1% (Weinberger) suggests. However, the key issue is whether they can indeed be annualized. This is where logic has been sacrificed, apparently for the sake of dramatic impact.

"The objective and thoughtful observer would be hard pressed to conclude that a period of obvious price single 'catch-up' would continue for an entire year. Much of the three month's increase represents those needed adjustments that physicians could not make during the previous 30 months, which saw the all-items index increase 17.8% and the cost of food increase 32.2%, while physicians' fees rose just 11.1%."

The CMA President then went on to point out that the three months chosen were those immediately following the lifting of the freeze. Subsequently, "following a brief period of fee adjustments, physicians are returning to a pattern of moderate escalation in their charges, particularly in light of unprecedented escalation in other sectors of the economy." □

## Board of Medical Examiners Statistical Report Released

A statistical report on the distribution of physicians in Oklahoma has been released by the State's Board of Medical Examiners. The report shows that as of October 15th, 1974, there were 2,804 physicians licensed in the state, 1,559 licensed outside the state, and 142 in military service. The total number of physicians eligible to practice in the state is 4,505.

As could be expected, over half of Oklahoma's licensed physicians, 1,627, are located in cities with populations over 100,000. Seven hundred ninety nine are in cities with populations over 10,000; 175 in cities over 5,000; 92 in cities over 2,500 and 111 are practicing in cities with populations under 2,500.

Of the 2,804 physicians in Oklahoma, 1,480 are graduates of the University of Oklahoma College of Medicine. Of the 4,505 total eligible



for practice in the state, 2,532 are OU graduates.

One hundred physicians currently licensed in Oklahoma are graduates of foreign medical schools. There are 145 female physicians in the state.

Oklahoma County has more licensed physicians than any other, with a total of 1,124. Tulsa is second with 601, and Cleveland is third with 106. Muskogee County has 84, Comanche 61, Washington 59, Garfield 58, Kay 49, Payne 46, and Carter has 45 licensed MDs. For the next three in line are Pottawatomie, Pontotoc and Pittsburg with 36, 35 and 31.

Oklahoma still has one county, Dewey, in which there is no registered medical doctor. Six counties have only one each and eight have two each.

While the lion's share of Oklahoma physicians are graduates of the Oklahoma University College of Medicine, 55 are graduates of the University of Arkansas, 35 are from the University of Kansas, 34 from the University of Texas Southwestern Medical School, and 28 from the University of Texas Medical Branch.

Medical doctors licensed in Oklahoma have graduated from a total of 81 medical schools across the nation and 93 foreign medical colleges.

Since 1956, a number of licensed medical doctors in practice in the State of Oklahoma has increased from 2,144 to 2,804, an increase of 660. The total number eligible to practice in Oklahoma, licensed but not currently in the state, increased from 2,730 to 4,505, an increase of 1,775. □

**DEATH**

**WILLIAM D. HAMILTON, MD**  
1945-1974

William D. Hamilton, MD, 29-year old surgery resident, died in Oklahoma City October 4th, 1974. Doctor Hamilton was born in Belleville, Illinois and was graduated from the University of Oklahoma College of Medicine in 1971. He had been serving his residency at the University of Oklahoma Health Sciences Center. Doctor Hamilton was a member of the Alpha Omega Alpha. □

**Lupus Association  
Will Hold Workshop**

The Oklahoma Lupus Association will present a two-day workshop on December 13th and 14th at the Center of Continuing Education, Norman. Sponsored by the Oklahoma College of Nursing, theme for the meeting will be "Lupus—What's That?"

Physicians will speak on the diagnosis, treatment and characteristics of Lupus Erythematosus at the workshop. A panel composed of lupus patients will speak on how the disease has affected their life-style and a spouse and nurse will tell how they are involved in the care of patients. It is hoped that this workshop will be the starting point for better training in nursing schools, better training in medical schools, more public awareness of the disease and more consumer and family awareness in this area. This is the first time that health care consumers have taken part in continuing education of this type.

All members of the medical profession, lupus patients and relatives are encouraged to attend this two-day seminar.

Persons interested in attending this meeting should write to Marian E. Grier, Assistant Professor of Nursing, University of Oklahoma College of Nursing, P.O. Box 26901, Oklahoma City, Oklahoma 73190. □

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## House of Representatives Reorganization Called "Minor"

What had been billed as a major reorganization of the United States House of Representatives Committee structure actually resulted in only "minor changes in the deeply entrenched establishment" according to the McGraw-Hill publication *Washington Report on Medicine and Health*.

House members approved a substitute for a sweeping reorganization bill that had been proposed by a special committee. The substitute was authored by a democratic caucus committee and passed the House by a vote of 203 to 165.

The reorganization changed the Interstate and Foreign Commerce committee to the new Commerce and Health Committee and assigned to it the responsibility for health legislation involving Medicaid and maternal and child health programs titled XIX and V of the social security amendments.

Title XVIII, or Medicare, remains with the Ways and Means Committee as would any con-

sideration of a tax financed national health insurance plan. According to the Washington report, the rationale is that "payroll tax financing lies under the jurisdiction of the tax writing Ways and Means Committee. Medicaid and maternal and child health programs are financed out of general revenues."

In order that its committees might more closely parallel those of the Senate, the House created a new Select Committee on Aging as a counterpart to the long-standing Senate committee. The new committee will have no authority to write legislation, but will investigate such areas as health care programs involving the elderly and will be able to hold hearings on these matters.

An innovation that some Washington observers are hailing as much needed is a requirement that whenever any committee of the House reports on a bill, the report will include a detailed analytical statement on the measures inflationary impact on the economy. Reports from the appropriations committee must include a description of what changes any provision of the accompanying bill would have on existing law. □

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## Book Review

**Progress in Medical Genetics.** Edited by Arthur G. Steinburg, PhD and Alexander G. Bearn, MD pp 319. Grune and Stratton, Inc., New York, 1972, \$19.50

As the title implies, this monograph is a review of recent advances in medical genetics. It will thus be of interest primarily to basic scientists and clinicians in academic settings who are concerned with various aspects of genetics. German's chapter entitled, "Genes which Increase Chromosomal Instability in Somatic Cells Predispose to Cancer" is one of the more thought provoking and controversial of the volume. The chapter by Clark entitled, "Prevention of RH Isoimmunization" is a thorough, comprehensive treatment of the subject which leans perhaps a bit heavily on the historical development but at the same time is an excellent analysis of the current state of the problem. Kirkman's review of enzyme defects is comprehensive and up-to-date. Perhaps the most interesting chapter is that by Scott entitled, "The Genetics of Short Stature." His genetic theme is poignantly illustrated by the photograph from the National Annual Convention of the Little People of America.

For those with an interest in genetics this monograph is well worth reading. *Harris D. Riley, Jr., MD, Children's Memorial Hospital, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma* □

## Miscellaneous Advertisements

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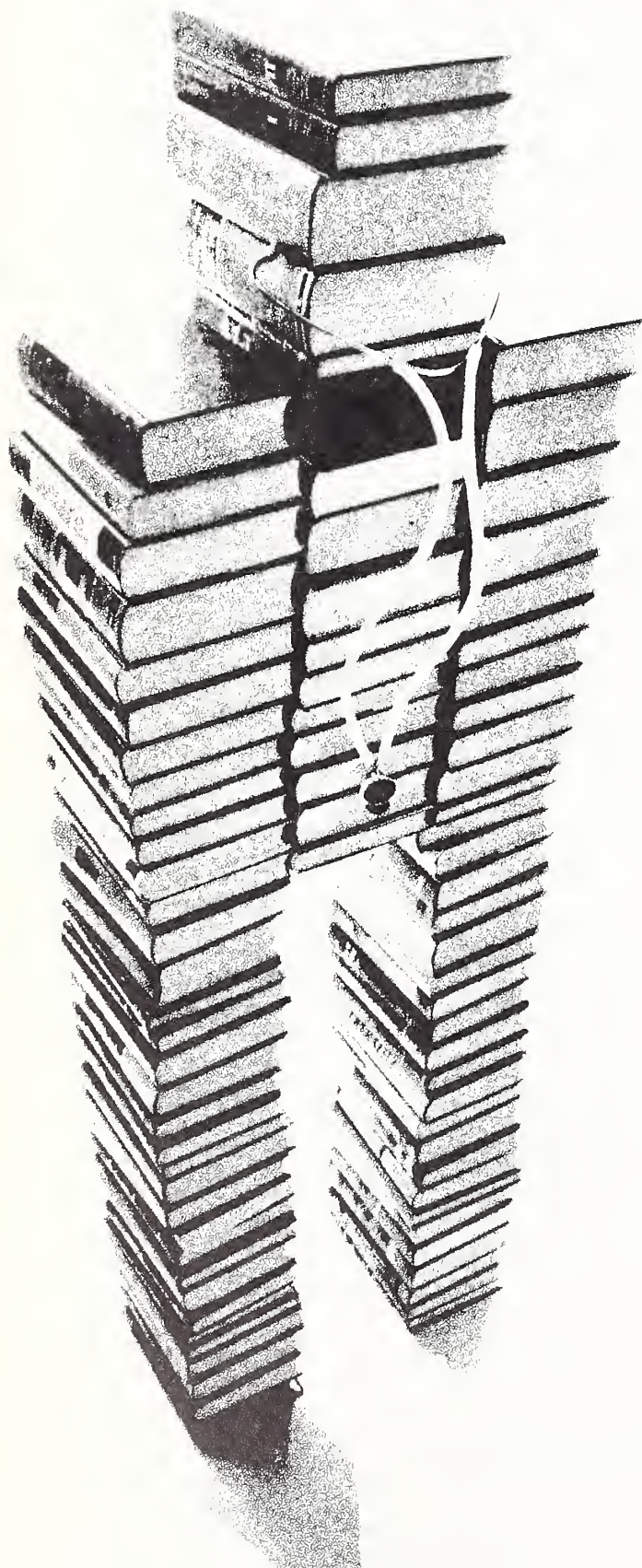
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535 North Dearborn Street/Chicago, Illinois 60610





## Be a Member — Gain a Voice

As an officer of the auxiliary, I am called upon to, if not justify, at least explain the value of membership in the auxiliary for a physician's wife.

First of all, by being a member of the auxiliary you are demonstrating support for your husband's profession, especially in these times when medicine is under attack by government and consumer groups. Yes, you can support his profession on your own, but the impact of one physician's wife speaking alone is not that of an organized group whose membership works to improve health education and service.

One of the benefits received from the auxiliary membership is first hand information about what is going on in medicine, not only in auxiliary work, but on government action and the practice of medicine. Each auxiliary member receives *M.D.'s Wife* as well as her state publication and special material from time to time. Meetings on the local and state level furnish further information on what is going on. Only from publications published by and for medicine will you get an inside view of what is happening to medical practice.

Also of importance is the opportunity to provide services which not only are vital to your community but enhance the public view of the medical profession. In most communities, the physicians' wives are among the most active and tireless community workers, in all sorts of activities ranging from Boy Scouts and Girl Scouts to the Red Cross and city councils and school boards. Recognition of that physician's wife as also a member and worker for the medical auxiliary is important to dispel any feeling that the doctor's wife is a pampered do-nothing.

One of the most important roles within medicine that a physician's wife can do is to support AMA-ERF. This undertaking, which is the only national fund-raising effort of the auxiliary, provides funds for two important areas. One is unrestricted monies awarded to deans of medical schools. The other provides a guarantee to banks for loan money to medical students, interns and residents. The total of the loan fund guarantees \$12 for every \$1 contributed. In this time when other loan money is diminishing and educational costs are rising, when federal loan money carries regulations that will affect later practice, this source of unhampered loan money is becoming increasingly important.

Friendship and fellowship with other physician's wives is another important part of medical auxiliary. Welcome to a new community by other wives can do a great deal to help establish a new practice and keep the physician in the community.

And last of all, and by no means, the least important, is courtesy to your physician husband. While all physicians may not agree with everything supported by the state medical association, they still belong since it is their voice to the outside. The physician's wife, whether as a member of an organized auxiliary or a member-at-large, owes her husband the courtesy of becoming a part of the auxiliary to demonstrate her loyalty to him and his profession. If any of you have not been contacted about joining auxiliary, please drop me a note at 2212 Cloverleaf, Ardmore, and I will get in touch with you.

Be a member of medical auxiliary. Gain a voice for medicine. *Patricia F. Brown, First Vice-President* □



**A dues increase will be sought** by the AMA during its clinical meeting in Portland, Oregon, in early December. The AMA's Board of Trustees will request its House of Delegates to approve an increase in annual dues for regular members from \$110 to \$200, effective January 1st. The last AMA dues increase was in 1971, raising the dues from \$70 to \$110.

The dues increase, if accepted by the House of Delegates, would be combined with a series of major realignments and consolidations designed to combat the AMA's rising costs while increasing services to its 170,000 dues-paying members. The board will recommend a balanced budget in excess of \$35 million, the elimination of two councils and 17 committees appointed by the board, the elimination of 11 committees appointed by the house, the reduction of the AMA staff to 950 persons, and a reduction of the number of issues of the *AMA Journal*, *Prism* and to change three of the ten specialty journals of the AMA (pathology, neurology, and environmental health) from monthlies to quarterlies.

**A Virginia Lawsuit decision**, involving regulations prohibiting advertising of retail prescription drugs, has apparently resulted in a recommendation that the Federal Trade Commission invalidate state laws and regulations that prohibit such advertising. The recommendation was contained in a "confidential" FTC Report that was obtained by the New York Times. The report recommended that all retailers be required to post the prices of such drugs in their stores and in-

clude a statement in any advertising which would urge consumers to "shop wisely to get the lowest possible price available from a pharmacy which offers the services you expect." According to the New York Times, the report estimated that savings to consumers, if the recommendations were adopted, were estimated to range from \$1.12 billion to \$10 billion during the next ten years. The proposals were made by the FTC Prescription Drug Task Force and apparently resulted after a three judge federal panel ruled that Virginia's regulations prohibiting such advertising were a violation of the Constitution's First Amendment Guarantee of Free Speech. A similar suit is pending in Oklahoma.

**Oh no, OSHA!** During its first year of operation the Federal Government's Occupational Safety and Health Administration, known as OSHA, issued 15,000 regulations. If you put a pencil to it, that comes out to 65 new regulations each working day. It's possible to make a career just out of reading them!

**A little charity goes a long way.** Father Flanagan's Boys Home, Boys Town, Nebraska, has started a new mail appeal for public contributions. In 1972, its mail solicitations were discontinued when it was revealed that Boys Town had a sizeable endowment fund. Its 1972 tax returns reported a total income of \$19 million, expenses of only \$10.5 million and assets on hand as of the end of that year of \$219 million. □



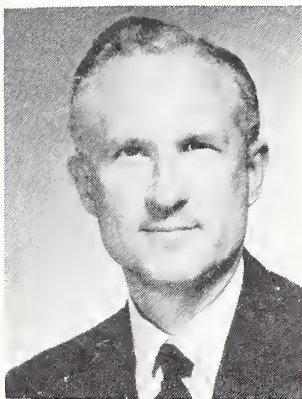


The Editors and Staff  
of The Journal and the  
Oklahoma State Medical Association  
extend to you and your loved ones  
our best wishes for  
A Joyous Holiday and  
A Happy New Year.





As I write this, the Portland meeting of the AMA has ended and resulted in a vote for a mandatory \$60 assessment of all members to bail out the association admitting to a budgetary deficit of \$3 million. This provides the possibility of obtaining \$9,600,000. Even with attrition of membership, there will still be far in excess of the immediate need. One



must wonder whether this generosity on the part of the delegates is justified, considering the fiscal record of the AMA Board of Trustees and its staff. The very obviously weak excuse for the largest deficit in the history of the AMA is that of inflation during the past three months. Yet this will be the fifth year in six that a deficit budget has been experienced. In any other business such fiscal management would not and could not be tolerated. As a delegate from Tennessee commented, "heads would roll." And indeed they should. The house has been all too generous and too tolerant of financial irresponsibility. The mere matter of an assessment or dues increase, furthermore, is the least of the problems, simply being a serious symptom of other inefficiencies. When the house, as a body, will ever discover this and will exert proper restraints, changes and controls remains a complete mystery to this writer. Reducing staff less than 5% and eliminating a few committees and councils is about as productive as prescribing an aspirin for a brain tumor.

I have made it a point during the past year to make inquiry among knowledgeable observers in and around the Congress in Washington and have been repeatedly advised that the AMA has one of the poorest images for credibility and has the most inefficient lobby.

We should investigate, each of us, and determine why this is so. In recent years we have had some great presidents at the helm of the AMA and we have another one this year. These have been men of great intelligence, foresight, honesty and competence. So what happens to their effect during their year in the presidency? Are they ignored by the Board of Trus-

tees? Are they countermanded in their attempts at improving the association for the doctor and his patients? If so, who is doing it?

To my mind the house of delegates must share some of the blame. When they continue, in these critical budgetary times, to vote for publication of such items as Prism — the cost of which is over \$1 million — it reveals their own priorities and economic judgments leave much to be desired. Most certainly it is a pretty publication printed on pretty paper, but it is a luxury item. And we were meeting to discuss how to correct a deficit budget!

The move to cease pharmaceutical advertising in our journal was soundly defeated since it would, at one and the same time, have reflected on the various state and specialty journals as well as imply that we felt vulnerable to accusations of bias. It is scheduled for reconsideration next June.

The assessment of \$60 is to be sent out direct from the AMA about January 1st, 1975. It is due then and payable, if you elect to remain a member. At the present time the rules and bylaws of your state association require membership in the AMA; to make AMA membership voluntary requires action by the Oklahoma House of Delegates at the annual meeting in April. If you vote to make AMA membership optional, rather than mandatory, as it now is, then membership in the AMA will be a matter of individual choice. What you do meanwhile relative to the matter of assessment of \$60 is your own decision. From the tenor of the Portland meeting, as well as that of the meeting last June in Chicago, I can give no assurance whatever that a \$90 annual dues increase will not be passed next June. Neither am I convinced that enough has been done to insure fiscal responsibility, managerial efficiency or productive intervention for the profession and the patients it serves. Neither have I seen in the budgetary report the acceptance of almost \$4 million by the AMA from HEW for PSRO activity.

Let me say, however, that whatever you do regarding your membership in the AMA, it becomes increasingly important that you maintain your membership in your county society, and state association; the credit which the AMA assumes for whatever gains have been made in private enterprise, both locally and nationally, were largely due to the efforts made by and through your local organizations.

*J. L. Richardson, M.D.*



# The Manipulation of Fractures Under Local and Vocal Anesthesia

WILLIAM A. MILLER, MD

*Many fractures can be safely and efficiently manipulated without anesthesia or with local Xylocaine infiltration into the fracture hematoma.*

In our enthusiasm for relieving pain and apprehension, we may at times be jeopardizing life itself for the victim of a minor accident. For centuries before the discovery of anesthesia, fractures were often adequately treated. Several points are of some value in adjusting this primitive technique to modern day practice.

The most common displaced fracture that does not require anesthesia is an angulated fracture of the distal radius in a child. For about ten years, my technique for these has been to wrap padded long arm plaster splints with gauze on the arm in the angulated position. The splints are extended distally over the fingers. As the plaster is firming up, the splints and the enclosed fracture are manipulated, slightly overcorrecting any greenstick fracture. The splints are then held firmly in a straight position over the fracture as the plaster sets. If the fracture looks as though it may have some instability, the splints may be held slightly bent

as felt necessary. With properly timed manipulation, this waiting period for good plaster setting is less than one minute. The distal ends of the splints are then trimmed back to the metacarpophalangeal joints.

The key element of this technique of manipulation of the splints and fracture without anesthesia or sedation is proper conversational preparation of the patient and parents. With little exaggeration, I explain that we can give the patient a shot or two and some gas with the possibility of his being sick and having to stay in the hospital, or that we can do it this way, "like pulling a tooth," and that there will be momentary pain, but that he will be on his way home in a few minutes. Only rarely is there more than a whimper from such patients. A line of chatter during the application of padding and plaster is probably worthwhile.

This method of manipulating the plaster splints requires the confidence of the manipulator that he will not have to do it twice. If the doctor is accustomed to making x-rays after manipulation and then applying plaster, this technique probably will not be much to his liking, but I have had excellent satisfaction from this method of fracture treatment. It not only saves the time spent waiting for the anesthesiologist, but does not subject the child to the possibility of an aspiration problem. The manipulation can be done in the office, avoiding a



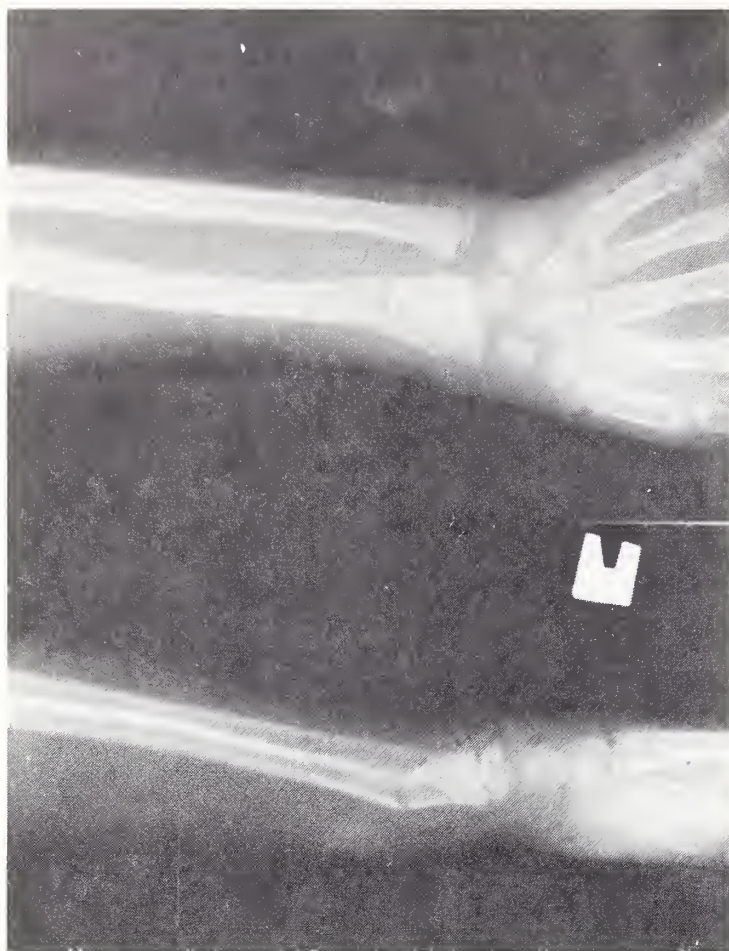


FIG 1  
Case #1. Angulated fracture of the distal radius.



FIG 2  
Case #1. Post-reduction films in plaster of the previously angulated fracture of the radius.



FIGS 3 and 4  
Case #2. Angulated both bones fracture of the middle third of the forearm.



FIG 5  
Case #2. Post-reduction films in plaster of the previously angulated both bones fracture of the forearm.



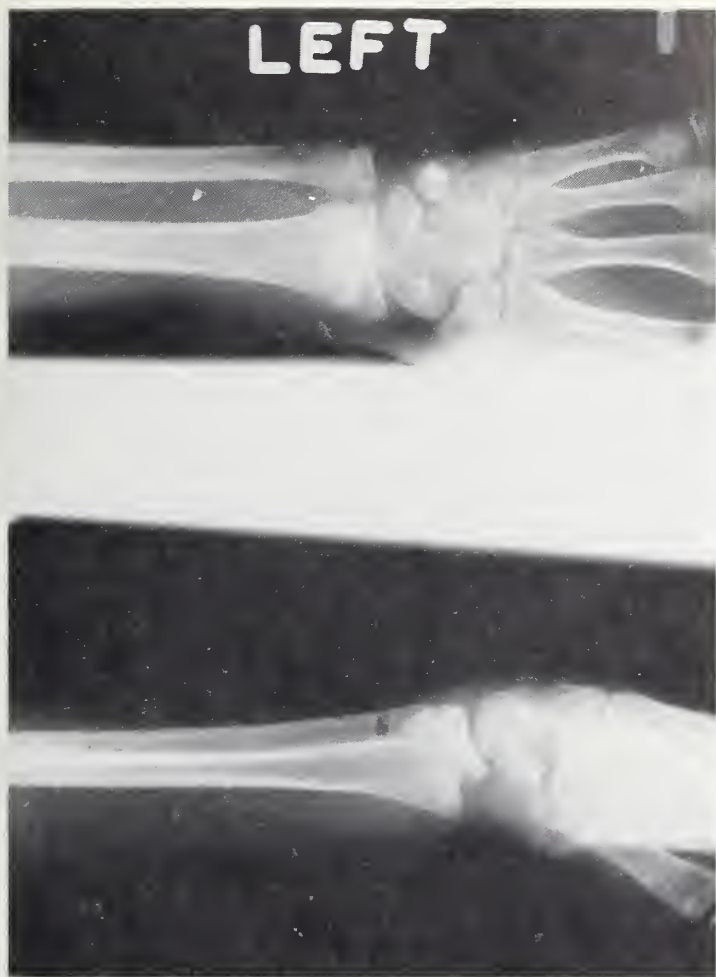


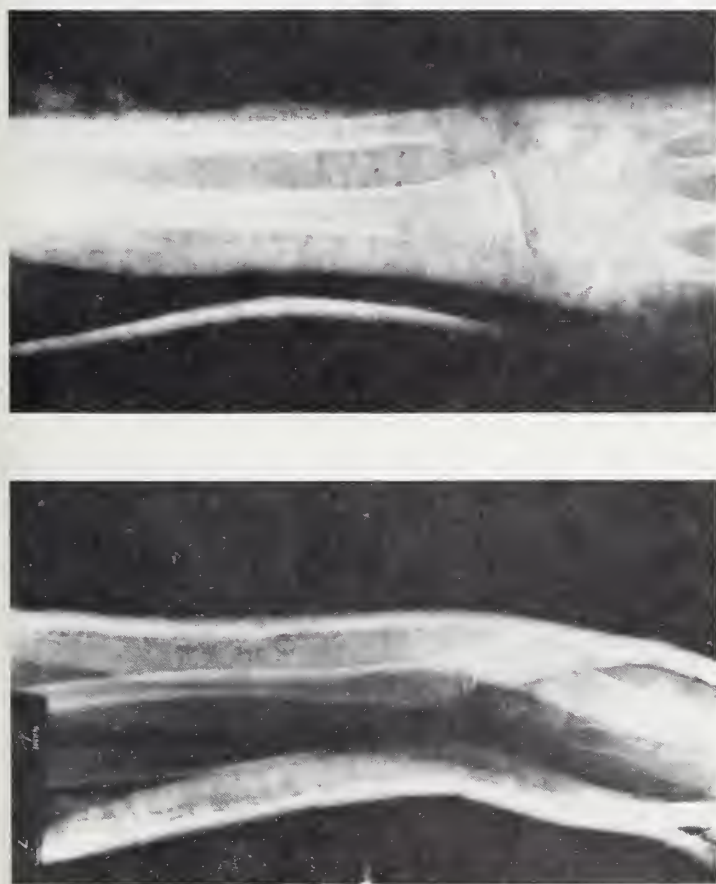
FIG 6

Case #3. Fracture of the distal radial epiphysis with metaphyseal involvement showing marked dorsal displacement of the distal fragment.



FIG 9

Case #3. X-rays after healing of the fractured distal radial epiphysis on the day the plaster was removed.



FIGS 7 and 8

Case #3. Post-reduction films in plaster after reduction of the fracture of the distal radial epiphysis.



FIG 10

Case #4. Markedly comminuted Colles fracture.





FIG 11

Case #4. X-rays in plaster after reduction of the Colles fracture.

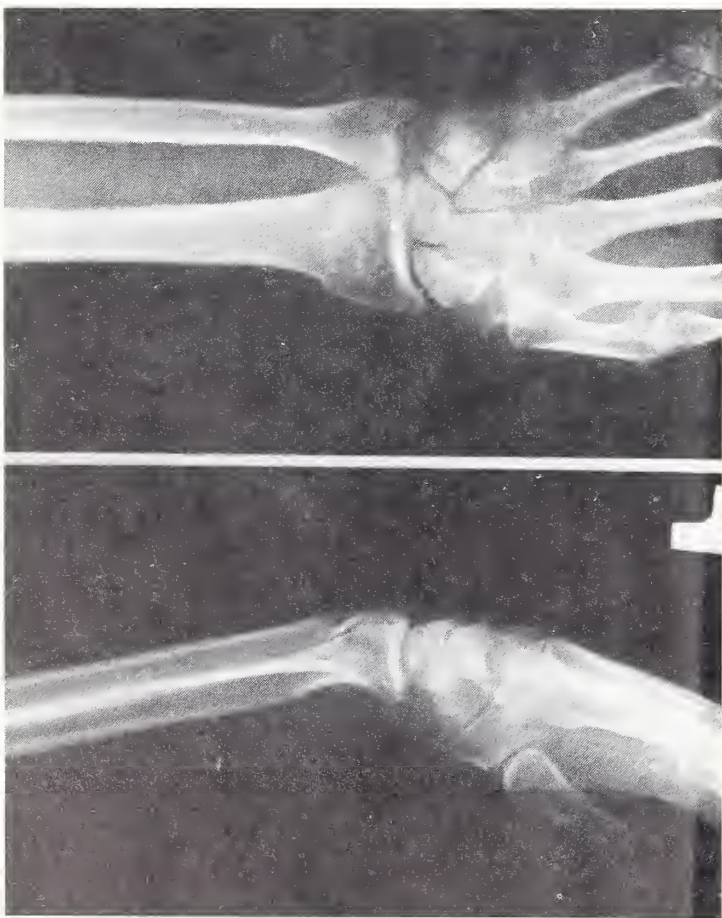


FIG 12

Case #4. X-rays after removal of plaster of the Colles fracture showing more clearly the marked dorsal comminution.



FIG 13

Case #5. X-rays of the fracture of the distal tibial epiphysis with a metaphyseal spike.

trip to the hospital, which even as an outpatient is expensive for the patient and time-consuming for everyone. We do have an Ambu bag and resuscitation kit available, but so far we have never had any difficulty with any patients treated by this technique or by local anesthesia.

Local anesthesia via a fracture hematoma is a well-recognized procedure. I have used Xylocaine routinely for Colles fractures and have not felt that its use has jeopardized results. After injection and manipulation of the fracture, long arm splints are applied on the Colles case. X-rays are then made. This technique can break down at this point if the position is not completely satisfactory and one does not have the courage to tell the patient that the job must be done again. My patients are warned in advance that I have to do this for about one case in ten. If I am not completely satisfied with the position, we simply remanipulate without hesitation.

A few words of caution should be given about the use of Xylocaine in children. A maximum dose for a 50-pound sturdy child is 7.5 cc of 1% Xylocaine. If a child is to be injected with Xylocaine the dose should be kept below this, and 2.0





FIG 14

Case #5. X-rays made through plaster following the reduction of the distal tibial epiphysis and attached spike.



FIG 15

Case #5. Final x-rays on removing the cast from the fracture of the distal tibial epiphysis with the metaphyseal spike.

cc injected into a small child's bone is plenty. In an adult, 10 cc of Xylocaine are injected into a Colles fracture.

*Since his graduation from the University of Oklahoma College of Medicine in 1947, William A. Miller, MD, has been certified by the American Board of Orthopedic Surgery. Doctor Miller is Clinical Professor of Orthopedic Surgery at his school of graduation and a member of the American Academy of Orthopedic Surgery, the Clinical Orthopedic Society and the American Orthopedic Foot Society.*

In using local infiltration into a fracture, the most important factor in obtaining satisfactory anesthesia is to wait at least 10 minutes after the injection before doing any manipulation.

#### ILLUSTRATIVE CASE REPORTS

Case #1 (Figs 1 and 2). This patient is a nine-year-old girl with an angulated fracture of the radius. This was treated by manipulation of the splints after application to the arm in its displaced position without any anesthesia or sedation.

Case #2 (Figs 3, 4, and 5). This is an eight-year-old boy with a middle third fracture of both bones of the forearm. This is such a ticklish area that I really prefer to reduce this type of injury under general anesthesia, fearing that overlapping might occur if the child gets excited and moves. He had just eaten. The radius and ulna were injected with 1.5cc of Xylocaine. The hematoma was entered on the radius, but no blood could be aspirated from the ulna before injection. The splints were then applied and manipulated.

Case #3 (Figs 6, 7, 8, and 9). This is a fourteen-year-old boy with a displaced fracture of the distal radial epiphysis with metaphyseal involvement. Five cubic centimeters of Xylocaine were injected into the fracture hematoma. The fracture was manipulated, and long arm splints were applied.

Case #4 (Figs 10, 11, and 12). This patient is a fifty-five-year-old woman with a Colles fracture. She was given 10 cc of Xylocaine, injected into the fracture hematoma before the original x-rays were obtained. I was in the emergency room before she was, and the diagnosis appeared obvious. She was free of pain in just a few minutes, and x-rays were obtained. The fracture was then manipulated and long arm splints applied. The final film on this case is shown to demonstrate that it actually turned out better than many Colles fractures with dorsal comminution.

Case #5 (Figs 13, 14, and 15). This patient is an eleven-year-old girl with a displaced fracture of the distal tibial epiphysis with a metaphyseal spike. The fracture hematoma was injected with 10 cc of Xylocaine and reduced with ease. A long leg cast was applied. □

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# A Survey of Cancer-Related Activities In the State of Oklahoma

G. BENNETT HUMPHREY, MD, PhD  
LYNN COLQUITT

*A statewide survey indicates a need  
for a network program for management of  
cancer cases with consultation and  
specialized services.*

In March of 1973, the University of Oklahoma Health Sciences Center (OUHSC) was awarded a planning grant from the National Cancer Institute which has allowed Oklahoma to enter into a two-year planning process for the development of a broad-based cancer program. This program is part of former President Nixon's announced plan of 1971 for the Conquest of Cancer. This program and its relationship to the State of Oklahoma was reviewed last year in *The Journal* in an article entitled, "The Conquest of Cancer — A Plan for Oklahoma."<sup>1</sup>

Since receiving the grant, a multi-disciplinary/multi-professional committee at the OUHSC has been collecting information in collaboration with a professional consulting firm. This information has been reported in six published documents:

1. COMPREHENSIVE CANCER PROGRAMS — STATE OF OKLAHOMA, September 1, 1973
2. Summary Report, PROJECTED CANCER INCIDENCE — STATE OF OKLAHOMA — 1970-1990, September 24, 1973

3. Detailed Report, PROJECTED CANCER INCIDENCE — STATE OF OKLAHOMA — 1970-1990, September 24, 1973
4. ABSTRACTS OF CANCER RESEARCH AND EDUCATIONAL PROJECTS — STATE OF OKLAHOMA, November 9, 1973
5. STUDIES OF PHYSICIANS' ATTITUDES IN HOSPITAL UTILIZATION TRENDS FOR CANCER PATIENT MANAGEMENT IN OKLAHOMA, December 14, 1973
6. STUDY OF HOSPITAL RESOURCES FOR CANCER MANAGEMENT IN OKLAHOMA, December 14, 1973

This report to *The Journal* will briefly review some of the information obtained in the published reports, especially that which relates to the physician survey and the survey of state hospitals.

The planning process has been underway for 15 months with an anticipated completion date of March, 1975. The first phase of the planning process has evaluated the present resources existing in Oklahoma. We will use this resource data base to determine what new programs are needed to meet all the obligations of a comprehensive cancer program. Feasible alternatives will be explored in an attempt to select the best overall plan. The current planning indicates that a network program must be established with primary emphasis on the management of cancer cases at network hospitals throughout the state. Consultation and specialized services, including educational programs, must be provided.

During the period from June to September, 1973, the committee distributed an initial survey questionnaire and an identical follow-up



questionnaire to a target group of medical and osteopathic physicians in Oklahoma. This target group consisted of physicians in 24 medical specialties involved primarily in the care of patients with cancer. A total of 2,166 medical physicians were surveyed, with 40% responding. Of the 324 osteopathic physicians surveyed, 47% responded.

Overall, attitudes toward a cancer center were basically the same for both medical and osteopathic physicians. They expressed interest in the possible utilization of a cancer program providing specialized cancer surgery, radiation therapy, and consultations in cancer manage-

ment. The provision of cancer detection programs and the latest diagnostic capabilities, plus continuing education in oncology and oncology-related subjects were shown to be the greatest advantages of the statewide cancer program. The major disadvantages noted were the possible duplication of existing adequate diagnostic capabilities and the possibility that physicians referring patients to any treatment component of a cancer program might lose contact with their patients. A specific analysis of physicians' attitudes toward the advantages or disadvantages of a statewide cancer program is given in Table 1.

TABLE 1  
SURVEY OF MEDICAL PHYSICIANS & SURGEONS  
ADVANTAGES/DISADVANTAGES OF A CANCER PROGRAM  
PROJECTED PERCENTAGE OF PHYSICIANS BY SPECIALTY GIVING AN OPINION

ADVANTAGES/DISADVANTAGES	GEN. PRACTICE & FAM. PRAC.	INTERNAL MEDICINE	GENERAL SURGERY	OB-GYN	PEDIATRICS	ONCOLOGY	RADIOLOGY	RADIATION THERAPY	OTOLARYNGOLOGY	STATE TOTAL
<b>ADVANTAGES</b>										
Provision of Cancer Detection Programs	60	59	68	60	56	46	47	100	73	58%
Provision of Cancer Diagnostic Capabilities	60	58	56	56	55	77	46	100	54	56%
Provision of Consultation in Cancer Management in										
Chemotherapy	54	56	45	50	50	46	39	50	45	48%
Cancer Surgery	44	39	34	40	53	46	36	50	45	40%
Radiation Therapy	47	45	38	44	53	69	38	50	45	43%
Provision of Treatment Capabilities in										
Chemotherapy	49	51	40	47	54	31	29	50	49	45%
Cancer Surgery	43	40	31	46	54	31	25	50	50	36%
Radiation Therapy	45	47	34	43	55	30	30	50	50	41%
Provision of Continuing Education	58	65	68	62	67	100	50	50	57	58%
Provide Local Physicians With										
Participation in Research Protocols	40	37	34	30	36	54	36	50	29	35%
Provision of Cancer Registry	40	48	45	46	30	46	46	100	37	41%
Other	3	4	3	2	4	0	0	0	0	3%
<b>DISADVANTAGES</b>										
Adequate Cancer Detection Programs Available	24	26	27	29	13	0	19	50	16	24%
Adequate Diagnostic Capabilities Available	28	38	46	36	22	0	32	0	39	33%
Adequate Consultation Service Available in										
Chemotherapy	25	31	40	27	13	23	24	50	37	28%
Cancer Surgery	28	38	43	33	15	23	23	50	51	32%
Radiation Therapy	27	23	46	31	13	23	30	50	49	30%
Adequate Treatment Capabilities Available in										
Chemotherapy	25	29	42	30	19	23	29	50	40	28%
Cancer Surgery	28	35	46	35	15	23	29	50	55	32%
Radiation Therapy	26	28	43	36	9	23	30	50	50	30%
Adequate Continuing Education Available	12	17	20	22	13	0	11	0	6	14%
Referring Physician Will Lose Contact With Patient	36	28	27	28	15	0	29	50	41	28%
Other	5	9	6	8	8	0	6	0	8	6%



## Survey/HUMPHREY, COLQUITT

Hospital utilization trends for cancer patient management by physicians in the State of Oklahoma were also analyzed. Medical physicians within Oklahoma refer approximately 15% of their cancer patients out of their local area for diagnosis or consultation, for both primary and secondary treatment. Both Oklahoma City and Tulsa physicians referred very few patients to other areas. The southwest and northwest regions bordering the Oklahoma Panhandle recorded the highest rates of referral. The survey indicates that hospitals in Oklahoma City have the widest geographic distribution for utilization among the medical physicians in the state. The survey also indicated three other state metropolitan areas serving as major referral areas for cancer patients: Tulsa, Enid, and Lawton. Other regional re-

ferral areas within the state were identified and are presented in detail in the referenced Study of Physicians' Attitudes in Hospital Utilization.

The study of hospital resources for cancer patient management in Oklahoma was prepared from a questionnaire sent to 142 general medical-surgical hospitals during the period of June to September, 1973, with 50% responding. However, 83% of all hospitals having more than 100 beds responded to the questionnaire, so this return included hospitals providing approximately 70% of all general medical-surgical beds. Military hospitals were excluded from the survey. In addition to data gathered through the questionnaire, the committee obtained information by personal and telephone interviews, written material, and the physicians' questionnaire. Information pertinent to radiation therapy resources was taken from the results of the survey conducted in April, 1973, by the State Chairman of the Committee for

TABLE 2  
ADVANTAGES/DISADVANTAGES OF A CANCER PROGRAM  
PERCENTAGE OF RESPONDENTS STATEWIDE GIVING AN OPINION

ADVANTAGES/DISADVANTAGES	STATE TOTAL
<b>ADVANTAGES</b>	
Provision of Cancer Detection Program	76%
Provision of Cancer Diagnostic Capabilities	54%
Provision of Consultation in Cancer Management in	
Chemotherapy	51%
Cancer Surgery	49%
Radiation Therapy	49%
Provision of Treatment Capabilities in	
Chemotherapy	47%
Cancer Surgery	47%
Radiation Therapy	42%
Provision of Continuing Education in Oncology	47%
Provide Local Physician with Participation in Clinical Research Protocols	42%
Provision of Central Cancer Registry	46%
Other	2%
<b>DISADVANTAGES</b>	
Adequate Cancer Detection Program Presently Available	5%
Adequate Diagnostic Capabilities Presently Available	12%
Adequate Consultation Service Presently Available	
Chemotherapy	14%
Cancer Surgery	12%
Radiation Therapy	14%
Adequate Treatment Capabilities Presently Available	
Chemotherapy	15%
Cancer Surgery	12%
Radiation Therapy	14%
Adequate Continuing Education in Oncology Currently Existing	3%
Referring Physician will Lose Contact with Patient	10%
Other	2%



TABLE 3  
PROJECTED CANCER INCIDENCE BY AGE GROUP  
STATE OF OKLAHOMA  
1970—1990

YEARS	1970	1975	1980	1985	1990
<b>Age Group</b>					
Less Than 15 Years	79	77	77	83	88
15—24	155	182	189	171	165
25—34	358	401	503	592	613
35—44	576	586	611	683	849
45—54	1164	1162	1149	1176	1223
55—64	2033	2036	2075	2078	2056
65—74	2485	2653	2774	2791	2849
75+	2206	2345	2354	2545	2633
Total All Age Groups	9056	9442	9732	10,119	10,476

Cancer Management of the American College of Radiology. Since physicians manage cancer patients, the number and types of physicians practicing on hospital staffs were considered to be primary resources for patient care. Cancer detection and diagnostic resources of hospitals were also analyzed, as well as tumor registries and educational programs.

The recipients of the hospital questionnaires were asked what advantages and disadvantages would accrue to their institution and their community if a comprehensive cancer program were established in the State of Oklahoma offering clinical diagnosis and treatment, basic and applied research, and continuing educational programs. Of those hospitals returning the questionnaire, 82% responded to this question. Table 2 shows the compared frequency

with which certain advantages or disadvantages of the cancer program were listed by the hospitals answering the questionnaire.

A detailed projected cancer incidence for the State of Oklahoma from 1970 to 1990 was published in September, 1973, as part of the overall planning process. This summary of the gross cancer incidence projection for the state over a 20-year period was based on the cancer incidence rates developed from the third national cancer survey. The projected cancer incidence by age is given in Table 3. Further analysis of this study gives the anticipated incidence of cancer by type and also a distribution of cancer cases by county.

The Cancer Program Committee was unable to publish sufficient numbers of the surveys of physicians and hospital management for distribution to all physicians, but copies of these two reports have been mailed to every hospital administrator in Oklahoma for the convenience and use of each physician. If there are any questions relating to information contained within the reports or this review article, please forward them to the Cancer Program Office, Post Office Box 26901, Oklahoma City, Oklahoma 73190. □

*A 1960 graduate of the University of Chicago, The School of Medicine, G. Bennett Humphrey, MD, PhD, is presently Chief of the Hematology/Oncology Service at Oklahoma Children's Memorial Hospital. His medical affiliations include the American Academy of Pediatrics, the American Society of Clinical Oncology, the Society for Pediatric Research and the XI International Cancer Congress.*

*Lynn Colquitt was graduated from the Georgia Institute of Technology in 1960. He has conducted planning activities for comprehensive health center programs and cancer research centers at several universities and health centers and recently helped develop a state-wide network for the cancer program in Oklahoma.*

#### ACKNOWLEDGEMENTS

The authors wish to express their appreciation to Barbara Wilson and Kendra Denman for clerical assistance and to Lois Fagan for editorial assistance. P.O. Box 26901, Oklahoma City, Oklahoma 73190.

#### REFERENCE

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## News From The Oklahoma State Department of Health

### RUBELLA IMMUNIZATION A NEW DILEMMA

Although Rubella Immunization programs have been relatively successful, Immunization Action Month has caused us to look directly at the heart of the problem. Rubella in the first trimester of pregnancy is associated with such a high incidence of fetal defects that we must prevent Rubella in the first trimester of pregnancy or seriously consider terminating the pregnancy. Since the latter alternative is not uniformly acceptable, the former choice seems worth considering.

Some states, such as Colorado, require a Rubella titer as well as a syphilis serology for legal marriage. Clearly this identifies the individual at risk, but how else might it help? Some

promise is shown in prevention of Rubella by immunizing the mother in the immediate postpartum period, observing a reliable birth control method. Recent epidemics of Rubella on college campuses and in the Armed Forces, have demonstrated the shift in susceptible age groups.

Immunization in postpubertal females is not without risk. We do not know the effect on the fetus of live Rubella vaccine virus, but it has been isolated from fetal material related to inopportune immunization. We do not know with certainty if it would be teratogenic. The second risk is arthralgia and arthritis, usually temporary, due to the vaccine virus, which approaches 30% in adults. To many, arthralgia and arthritis are clearly preferable to the risk of a deformed infant, especially to those who have cared for even one "Rubella baby."

The dilemma is risking a teratogenic infection, a terminated pregnancy, or the side effects of immunization. Unless the side effects can be eliminated and efficacy of immunization proved, many will retain Neroian posture. □

### COMMUNICABLE DISEASES IN OKLAHOMA FOR OCTOBER, 1974

DISEASE	October 1974	October 1973	September 1974	Total To Date	
				1974	1973
Amebiasis	2	2	2	26	28
Brucellosis	2	1	2	9	5
Chickenpox	61	3	10	933	1316
Encephalitis, Infectious	8	2	3	51	98
Gonorrhea (Use Form ODH-228)	1072	1013	960	9415	9243
Hepatitis, A, B, Unspecified	62	71	58	850	990
Leptospirosis	—	—	—	2	—
Malaria	3	1	—	6	3
Meningococcal Infections	1	2	—	16	33
Meningitis, Aseptic	3	5	10	60	101
Mumps	9	13	3	397	458
Rabies in Animals	16	5	14	146	150
Rheumatic Fever	1	—	2	12	14
Rocky Mountain Spotted Fever	4	4	5	62	76
Rubella	3	—	3	62	180
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	2	1	2	29	56
Salmonellosis	34	47	31	237	248
Shigellosis	12	14	30	151	176
Syphilis, Infectious (Use Form ODH-228)	11	10	16	121	145
Tetanus	—	—	—	2	4
Tuberculosis, New Active	43	31	11	270	273
Tularemia	4	3	1	18	22
Typhoid Fever	—	—	—	2	2
Whooping Cough	—	—	2	16	21

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## OSMA Professional Liability Insurance Premium Increases

Oklahoma physicians will have to pay about 20% more for their Professional Liability Insurance during 1975. Even with the increase, physicians in the OSMA program will be paying far less than their colleagues purchasing the same coverage outside the association.

The association's recommended coverage is written by Pacific Employers Indemnity Company, a wholly owned subsidiary of the Insurance Company of North America. The company has been writing the policy since January 1st, 1967.

While INA's rates were going up 20% in 1975, other companies writing the same coverage in Oklahoma and belonging to the National Insurance Rating Bureau have asked for a 60% increase.

Class 1 premiums for 1975 will be \$203, Class 2 will be \$356, Class 3 will be \$708, Class 4 will be \$943, and Class 5 will be \$1,180. In each instance other companies in the state will be charging two to three times that amount.

The premium increase, which was approved by the OSMA's Council on Insurance, was brought about by a combination of inflation and increased loss experience. Oklahoma's situation is still far better than other states, however, where insurance companies are abandoning the professional liability field altogether.

Another change that is projected for the future of the program is the method being used to classify physicians. Currently there are five classes, but many companies writing professional liability coverage are going to 12, or more, classes. The multiple class system is supposed to give the companies better actuarial information.

INA will retain its five classes as follows: Class 1 applies to general practitioners and specialists who do not perform obstetrical procedures or surgery other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia, and who do not ordinarily assist in surgical procedures.

Class 2 applies to general practitioners and specialists who perform minor surgery, including obstetrical procedures not constituting major surgery, or assist in major surgery on their own patients. For purposes of this class, tonsillectomies, adenoidectomies, and cesarean sections shall be considered major surgery.



Class 3 includes general practitioners, who perform major surgery or assist in major surgery on other than their own patients, and specialists.

Class 4 includes cardiac surgeons, otolaryngologists not doing plastic surgery, general surgeons, thoracic surgeons, urologists, and vascular surgeons.

Physicians in Class 5 constitute those with the highest professional liability risk. This includes anesthesiologists, neurosurgeons, obstetricians-gynecologists, orthopedic surgeons, otolaryngologists doing plastic surgery, and plastic surgeons. □

## Health Maintenance Organizations Discussed by OSMA Trustees

While opposing the concept of a health maintenance organization, HMO, the OSMA Board of Trustees during its November meeting did resolve to work with the Oklahoma Legislature on an HMO law.

The trustees were concerned that many people might convince themselves that HMO's are "the answer" to a number of different health care delivery problems. The Legislative Committee of the OSMA has testified before a state legislative committee to the effect that HMO's will not solve the problems of indigent care, distribution of physicians or rising medical care costs. According to a report to the trustees, the committee stated, "in fact, supported arguments have been put forth substantiating the fact that premiums for enrollment in pre-paid health care plans (HMO's) exceed premiums for comprehensive health insurance coverage. Likewise, evidence has been put forth that indicates that the quantity of services delivered to the sick may, in fact, be diminished by the HMO and as a result, the quality of care could be compromised."

In spite of the testimony offered by the OSMA, the legislative committee is interested in drafting and submitting a bill to implement the HMO laws in Oklahoma. Thus far, 18 states have enacted special legislation permit-



ting the formation of health maintenance organizations.

In 1973 the United States Congress passed the Health Maintenance Act of 1973, now known as Public Law 93-222. This law called for the creation of HMO's and appropriated \$375 million to be spent over five years experimenting with the concept. One feature of that law requires that employers having more than 25 employees must offer, as a part of their health benefits package, the opportunity for their employees to join an HMO, if there is an HMO operational in their area. A number of large companies in Oklahoma have already directed inquiries to the medical association about the availability of this type of service in Oklahoma. A feasibility grant had been awarded to a physician-group in Okemah to study the possibility of an HMO in that area.

According to the report to the OSMA Board of Trustees, a number of lawyers in Oklahoma, the AMA's Legal Department, the Health Law Center and representatives of the Department of Health, Education and Welfare, are of the opinion that current Oklahoma law would place severe restraints upon a health maintenance organization. It might be "legally" possible to form such an organization in Oklahoma, but for all practical purposes it would be "organizationally" unfeasible.

Loss of personal contact with the patients was also a concern of the trustees. The very concept of the HMO itself must destroy the patient's right to choose his own physician, one of the very basic requirements of excellence in health care. □

## Trustees Adopt Union Report

A report on physicians' unions, prepared by the OSMA staff, was adopted by the association's Board of Trustees when it met on November 17th. The report was prompted by increased interest on the part of physicians in union activities for health care professionals.

The report points out that private practicing physicians cannot form a true union, *ie*, one that meets all of the requirements of the various federal laws, specifically the National Labor Relations Act.

The term "labor organization," or union, is defined as meaning any organization of "any kind, or any agency or employee representa-

tion committee or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment or conditions of work."

The key words in the definition are "employer" and "employee." In addition, while the definition of these terms is very broad, the law specifically excludes "any individual having the status of an independent contractor."

"These definitions would seem to exclude private physicians from operations of the National Labor Relations Act," the report said. "Since a patient is not and cannot be considered an 'employer' of the physician, then the physician cannot be considered an 'employee' as defined in the act."

The report goes on to state, "obviously, if physicians are employed by a hospital or other organization, then they could band together and form an organization to represent them to lawfully bargain concerning their wages, hours and conditions of employment.

"In this latter event, however, it would not be necessary for the physicians to form a separate organization and label it a 'union.' Their medical association or society can very easily meet the definition of a 'labor organization' as set out in the act. There is no magic in the word 'union' in the name of an organization.

"The apparent success of the so-called 'physicians' unions' existing around the country today is just that, more apparent than real. In a very limited number of special situations they have achieved some success. However, their success was due primarily to the fact that their membership was made up of a group of individuals of like mind. There was no dissent as to the action to be taken.

"The test of whether or not an organization is a true union comes in the face of dissent. A true union, via the federal statutes, can force a minority of its members to abide by a majority decision. This is done by controlling employment of the recalcitrant (member).

"A physicians' union is going to be hard-pressed to control the 'employment' of a recalcitrant physician-member. The first action that comes to mind, generally, is to 'limit his hospital privileges.' But private practitioners are not employees of hospitals, they are independent contractors.

"Hospital privileges are granted to physicians on an individual basis, not on a group



basis. In some limited instances a physician may be an employee of a hospital, but this is generally not the case."

The report goes on to point out that if one group of physicians did attempt to withhold hospital privileges in order to bring a recalcitrant member into line, they could find themselves in conflict with the various anti-trust acts.

The report to the trustees quotes a report from the California Medical Association regarding unions. That report ended by saying, "In short, because of the numerous legal and professional considerations, a physicians' union would be limited to the same activities presently being done by organized medicine."

The OSMA paper states, "Even if physicians can form true unions, there is no need for them to establish organizations separate from their state or county medical societies in order to do so. Without any change in structure a medical society can represent and bargain for employee physicians in relation to their employer. In addition, it can enter into 'unofficial' bargaining in order to accomplish the collective desires of its members in those situations where there is no true 'employer.' In this latter situation the

association can rely on its political clout, public relations, expertise and the possibility of a civil rights lawsuit to obtain concessions for its members."

In a special memorandum to the OSMA's Executive Director, Don Blair, Mr. Edward E. "Ted" Soule, a member of the law firm of Lytle, Soule and Emery, stated, "most representatives of organized labor consider that doctors and lawyers already have unions, in the form of the AMA, OSMA, ABA, OBA, etc. Of course, these are not unions at all in the legal sense, but they are organizations that exist with the benefit of their representative professions, served to further the benefit of their professional members, and in the eyes of union people, they are 'unions.'"

Mr. Soule goes on to point out, "if private practitioners were to join some new organization called a 'union,' it would really be no more than another professional association, and of course could not accomplish any more for its members than can the OSMA. It would seem to us that an additional organization of this sort would tend to duplicate the function of the OSMA, and in effect would dilute the strength of organized medicine." □



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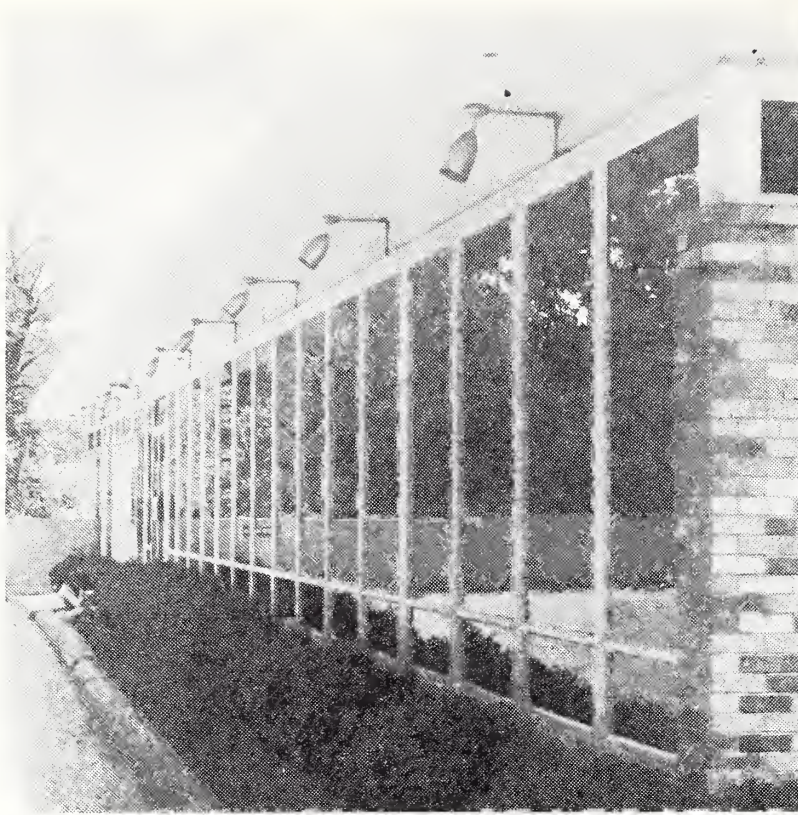
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## Doctor Baker, Former OSMA President, Dies

Doctor Alfred T. Baker, 69, 1123 West Elm Street, a Durant physician since 1934, died Saturday, November 2nd, 1974, at his home.

Doctor Baker was born in 1905 in Logansport, Indiana, received his medical degree from the University of Louisville in Louisville, Kentucky.

He came to Durant in 1934 where he was associated with the Colwick Clinic, which later became the Durant Clinic.

He was married to the former Frances McCord in August, 1934. Doctor Baker entered the medical corps of the 45th Infantry Division at the start of World War II and served until his discharge in 1945. During his military service he received two Bronze Stars with an Oak Leaf Cluster, and was discharged as a lieutenant colonel.

He was a member of the American Medical Association, the American Academy of Family Physicians, the Medical Industrial Association and a longtime member of the Board of Directors of the Crippled Children's Hospital in Oklahoma City. Doctor Baker was President of the Oklahoma State Medical Association from May, 1959 to May, 1960. He was also a member of the Chamber of Commerce, Rotary Club and the First United Methodist Church.

He is survived by his wife; a son, Mike of Sugarland, Texas; a daughter, Francie Hannon of Muskogee; a sister, Florence Baker of Chicago.

The family requests that memorials be made to the Doctor Alfred T. Baker Memorial Fund at Bryan Memorial Hospital, Durant, Oklahoma. □



Alfred T. Baker, MD

## Physician Speakers Bureau Revitalized and Updated

At the direction of the OSMA Public Policy Council and Public Relations Committee, the association is in the process of revitalizing its Speakers Bureau. Purpose of the bureau is to provide physician-speakers to lay organizations on health care and medical economic subjects.

The revitalization was ordered by M. Joe Crosthwait, MD, and Jake Jones, MD, chairman of the council and committee. In a letter to all OSMA officers, trustees, house of delegates members, and county medical society officers, the two chairmen stated, "one of the most effective public relations mechanisms at our disposal is the time our member-physicians are willing to spend in public meetings. The opinion of the physician is still one of the most highly regarded by the general public."

The letter was actually an invitation for the physicians to attend a special two-day training session that will be professionally conducted by the Smith, Kline and French speakers training team. It ends by pointing out that the revitalized Speakers Bureau will be actively publicized to civic organizations, schools, churches, and chambers of commerce.

In closing, the chairmen stated, "we, as physicians, often complain about our public relations. If you have made this complaint, here is an opportunity for you to do something about it, personally. If you have the desire and the ability to be a public speaker, please sign up for this training session and the Speakers Bureau."

The training session was conducted on December 14th and 15th at Lincoln Plaza Hotel in Oklahoma City. Over 50 physicians participated and will make up the nucleus of the new Speakers Bureau.

Each physician that attended the training session, and a number of others that agreed to serve on the bureau but could not attend the session, received a Speakers Bureau kit. The kit contained copies of "canned" talks on various subjects, and an assortment of resource material on each subject.

The existence of the bureau will be publicized by the production of a mailout brochure. Eight basic presentations will be advertised to interested organizations. At this writing, the final eight have not been selected, but will certainly include heart disease, quackery, cancer, smoking and health, alcoholism, and possibly something on drug abuse, medical economics, and national health insurance.

Another Speakers Bureau training session will be offered during "Summit '75" the combined annual meeting of the OSMA, Academy of Family Physicians and the Oklahoma City Clinical Society. The joint chairmen also stated that if interest is high enough, an additional training program may be offered sooner. □



## New Health Sciences Center Provost Named

William G. Thurman, MD, Dean of the Tulane University School of Medicine has been named provost of the OU Health Sciences Center. The new provost will assume his duties April 1st, 1975.

The announcement of the new provost was made by the OU Board of Regents during its meeting on November 14th. OU President, Doctor Paul F. Sharp, said Doctor Thurman is one of the nation's foremost health professional administrators and that he is personally delighted that Thurman has accepted the position.

The OU post was described by the new provost as "one of the best medical education opportunities in the United States. It is an honor to have been considered and offered the position. I am very pleased."

Acting provost since June of 1973 is Doctor William E. Brown, a dentist. Doctor Brown asked to be replaced in order to devote full time to his duties as Dean of the new College of Dentistry of OUHSC.

Doctor Brown described Thurman as a "sound decision maker" with "global views on the education of health professionals and health care delivery. His position on the HSC campus will be a real asset to the state."

Brown referred to his 18 months as acting provost at a time when "many more people of this fine state have begun to understand better the role and needs of the Health Sciences Center."

Doctor Thurman, 46, began his academic career in 1960 as an assistant professor of pediatrics at Tulane. One year later he was named associate professor of pediatrics at Emory University in Atlanta, Georgia.

In 1962 he became full professor at the Cornell Medical School in Ithaca, New York. He served as chairman of pediatrics at the Sloan Kettering Cancer Center in New York City and at the University of Virginia School of Medicine in Charlottesville.

While at Virginia, he also served from 1969



until 1973 as director of the Center for Delivery of Health Care.

Thurman earned a BS in Chemistry from the University of North Carolina prior to receiving his MD in 1954 from McGill School of Medicine, Montreal, Canada. His internship was served at City Hospital in Columbus, Georgia, and his residency at Charity Hospital in New Orleans.

He and his wife, Peggy, are the parents of three children, ages 19, 18, and 9.

Many applicants were considered for the provost position by the search committee. By mid-September the field of candidates had been narrowed down to 18 persons. By mid-October the committee had reduced the list to five and each of the candidates was interviewed personally on the OUHSC campus.

Chairman of the provost search committee was Doctor Oscar Parsons, Vice-Chairman of the Department of Psychiatry and Behavioral Sciences. Doctor Parsons had replaced Doctor Thomas Lynn as chairman of the committee after Lynn was appointed acting dean of the OU College of Medicine upon the resignation of Robert Bird, MD.

The search committee was made up of a combination of Health Science Center faculty and professional and lay personnel from across the state. Arnold G. Nelson, MD, President-Elect of the OSMA served as a member of the committee along with Raymond Weeks, a member of the Oklahoma Public Health Association.

Other members of the committee included James Saddoris, immediate Past-President of the Oklahoma Dental Association; Dean Crislip, Kerr-McGee Corporation representative; Edward Daley, Vice-President of the Public Service Company of Tulsa and Juanita Proctor with the Oklahoma State Nurses Association. □

## Myrtle Laughlin Memorial Lecture Slated

Aaron J. Marcus, MD, Chief of the Hematology Section, New York Veterans Administration Hospital, will present the Sixth Myrtle Laughlin Memorial Lecture in Hematology at the University of Oklahoma Health Sciences Center on February 20th, 1975 at 4:00 p.m. Title of the lecture will be "Current Concepts of Platelet Physiology" and will be presented in the East Lecture Hall of the Basic Sciences Building. □



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## Summit '75 Plans Super Scientific Session

Members of the Scientific Program Committee for Summit '75, the combined annual meeting of the OSMA, Academy of Family Physicians, and the Oklahoma City Clinical Society, are planning a super scientific program. Scheduled for April 24th-26th, the meeting will be held in Oklahoma City's Lincoln Plaza Forum.

Chaired by James Funnell, MD, the committee has scheduled over 60 hours of continuing medical education for physicians. Programs will be on such diverse topics as cancer, hypertension, allergy, arthritis and anesthesiology.

The Oklahoma Cancer Society, state and county divisions, are going to sponsor a full-day seminar on cancer. They will concentrate on surgical, radiological and chemical treatment.

Medical specialty groups that plan sessions during Summit '75 include the internists, psychiatrists, obstetricians-gynecologists, anesthesiologists, urologists, allergists and general surgeons.

In addition to the continuing education hours for physicians, a number of programs will be offered for allied medical personnel. As an example, the Nurses Association of the American College of Obstetricians and Gynecologists will conduct a one-day seminar for OB nurses. The pathologists will conduct a half-day seminar for medical technicians and cytopathologists.

On each of the three days there will be a luncheon for the physicians in attendance with a special speaker. The speaker on Thursday will be the President of the American Academy of Family Physicians, while the President of the AMA will be the guest speaker on Saturday. Friday's guest speaker will be Phillip Thorek MD, considered one of the nation's most dynamic physician-speakers.

The annual business meeting of the Oklahoma Academy of Family Physicians will take place at 10:30 a.m. on Thursday morning, April 24th. The opening session of the OSMA's House of Delegates will be held Wednesday evening, and the closing session will be Friday morning. The OSMA's reference committees will meet on Thursday morning, April 24th.

The installation banquet for the officers of the three organizations will be held Friday

evening, April 25th, in the Lincoln Plaza's Playhouse.

Special entertainment, scientific and medical demonstrations, exhibits and displays are planned for the three days. □

## National Organization Selects OU Faculty Member to Post

Doctor Ross E. Brown, Director of the Section of Diagnostic Ultrasound, Department of Radiological Sciences at the University of Oklahoma Health Sciences Center was elected President-Elect of the American Institute of Ultrasound in Medicine at a recent meeting of the organization held in Seattle, Washington. He had served the group as Vice-President and has also chaired several committees within the group.

The AIUM is a society interested in all phases of ultrasound in medical usage and encourages research, education and general use of this new diagnostic technique.

Doctor Brown is also currently serving as Educational Advisor for the technical society, the American Society of Ultrasound Technical Specialists. □

## International Swindle Involves Oklahoma Doctors

Oklahoma physicians, along with all the other physicians in the United States, were part of an international swindle aimed at defrauding physicians of \$185 each. Rapid action by the American Medical Association's Legal Department in conjunction with the District of Columbia Medical Society has resulted in a fraud order being issued by the US Post Office to effectively stop the swindle.

Physicians throughout the United States received in the mail what appeared to be an invoice for \$185 for the purchase of "The International Medical Directory of Physicians" by Mayo Research and Publishing Company. The statements were mailed from California but the return address on the so-called publishing company was Hong Kong.

Issuance of the postal fraud order on November 1st means that all mail addressed to the Hong Kong address will be stopped and returned to the sender. It was feared that in some



offices the doctors' assistants might routinely forward checks in response to the "invoice."

The AMA's Department of Investigation learned of the mailing almost immediately and promptly notified the Post Office in Washington, D.C.

The Mayo Research and Publishing Company, not to be confused with the Mayo Clinic, is not registered in Hong Kong, and British authorities there are also investigating.

It appeared that the names on the invoices had been picked up directly from the AMA's "*American Medical Directory*," a listing of all American physicians. This was done in violation of copyright without the knowledge or consent of the AMA. □

## Doctor Schilling Honored

John A. Schilling, MD, former Professor of Surgery at the University of Oklahoma Health Sciences Center, was honored at a combined meeting of the Oklahoma Chapter of the American College of Surgeons, the Oklahoma Surgical Association and the Oklahoma City Surgical Society on November 16th, 1974. Doctor Schilling was Chairman of the Department of Surgery from 1956 to 1974 and was responsible for developing one of the outstanding surgical training programs in the country. Earlier this year he accepted an appointment as Professor of Surgery at the University of Washington School of Medicine in Seattle, Washington.

The scientific program which was held at the Faculty House, was presented by former residents and faculty members under Doctor Schilling during his professorship here. Among those participating were G. Rainey Williams, MD, John A. Schilling Professor of Surgery and present Chairman of the Department at the Oklahoma Health Sciences Center; Gilbert S. Campbell, MD, Professor of Surgery at the University of Arkansas School of Medicine, Little Rock; and Rene Menguy, MD, Professor of Surgery at the University of Rochester School of Medicine, Rochester, New York. Presiding at the meeting were Edward E. Jenkins, MD, Tulsa and Doctors Frank H. McGregor, Orville L. Rickey, and William O. Coleman, Oklahoma City, all officers in the sponsoring surgical societies.

Following the scientific program a reception and dinner honoring Doctor Schilling was held at the Oklahoma City Golf and Country Club. □

## DEATHS

ALFRED T. BAKER, MD  
1905-1974

Alfred T. Baker, MD, Past-President of the Oklahoma State Medical Association, died in Durant on November 2nd, 1974. Doctor Baker received his medical degree from the University of Louisville School of Medicine in 1931 and had practiced in Durant since 1934 with the exception of time he served with the medical corps in World War II.

Active in medical and civic affairs, he had served as OSMA Councilor from his district for many years before assuming the Presidency in 1959. In 1958 he was elected to the Board of Directors of the Oklahoma Society For Crippled Children and had been the Oklahoma Delegate to the White House Conference on Aging in 1960.

MARY V. S. SHEPPARD, MD  
1892-1974

Mary V. S. Sheppard, MD, 82-year-old Oklahoma City physician, died November 15th, 1974. Doctor Sheppard was a native of Hardy, Texas, and the widow of the late Doctor Hubert Sheppard. A 1931 graduate of Rush Medical College, she established her practice in Oklahoma City in 1934, retiring in 1970. She was a member of the Phi Beta Kappa. □

## Acapulco Is Calling OSMA Physicians

The OSMA-sponsored tour to Acapulco, Mexico is proving to be very popular. Globetrotter International Travels, the company putting the tour together, has acquired a few more casitas at the Hotel Las Brisas. Physicians interested should call the OSMA immediately.

January 15th is departure date for the tour. In Acapulco persons on the tour will stay at the luxurious Hotel Las Brisas for six days and seven nights. Each couple will have its own casita and will share a private swimming pool with one other couple.



Transportation to and from Acapulco is by economy-class jet that will return January 21st.

The Las Brisas is considered one of Mexico's finest luxury hotels. Five tennis courts are available. Hospitality and entertainment is offered in the Arsonal Pub or the Dungeon. A common sight in Acapulco are the pink and white candy-striped jeeps of Las Brisas. These are for rent to hotel guests.

After all the casitas are taken, the OSMA will maintain a standby list to cover any cancellations. Physicians interested should immediately call the OSMA at Area Code 405, 842-3361. □

### **South American Tour Still Available**

Although it's filling rapidly, the OSMA's two week air-sea cruise along the "sunshine coast of South America" still has a few places left.

Oklahoma physicians will depart from Tulsa and Oklahoma City on January 28th for two weeks on the elegant Stella Oceanis cruise ship.

Physicians who are interested in the two-week tour should call the OSMA immediately. Prices on the cruise range from \$995 for an inside state room up to \$1,895 for a deluxe suite.

Throughout the cruise there will be a distinguished faculty to deliver 28 hours of classes on "emergencies and medical practice." While most of the classes will be conducted on ship-board, arrangements have been made with local professors in medical schools to conduct several workshops in the various ports of call.

During the cruise Oklahomans will visit Buenos Aires and Mar Del Plata, Argentina; Sao Paulo, Santos, Rio De Janeiro, Vitoria and Salvador (Bahia) Brazil. A special side trip is being offered to Brasilia and another to Iguassua Falls, Brazil.

The tour will return to Oklahoma City and Tulsa on February 10th. □

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## INTERNAL MEDICINE REVIEW COURSE 1975

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University of Oklahoma College of Medicine, Oklahoma City, Oklahoma

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**DATE      TITLE — SPEAKER**

January 15, Pulmonary Disease I—Robert M. Rogers, MD, Barry A. Gray, MD  
January 22, Pulmonary Disease II—C. Dowell Patterson, MD  
January 29, Diabetes, Hypoglycemia and Calcium—James Males, MD  
February 5, Metabolic and Respiratory—Robert D. Lindeman, MD; Acid Base Disturbances—Chris E. Kauf-  
man, MD  
February 12, Glomerulopathies Diagnosis and Management—Solomon Papper, MD; Anil K. Mandal, MD  
February 19, Urinary Tract Infection and Stones; Diagnosis and Management—Anthony Czerwinski, MD  
February 26, Infectious Disease I—Infectious Disease Section.

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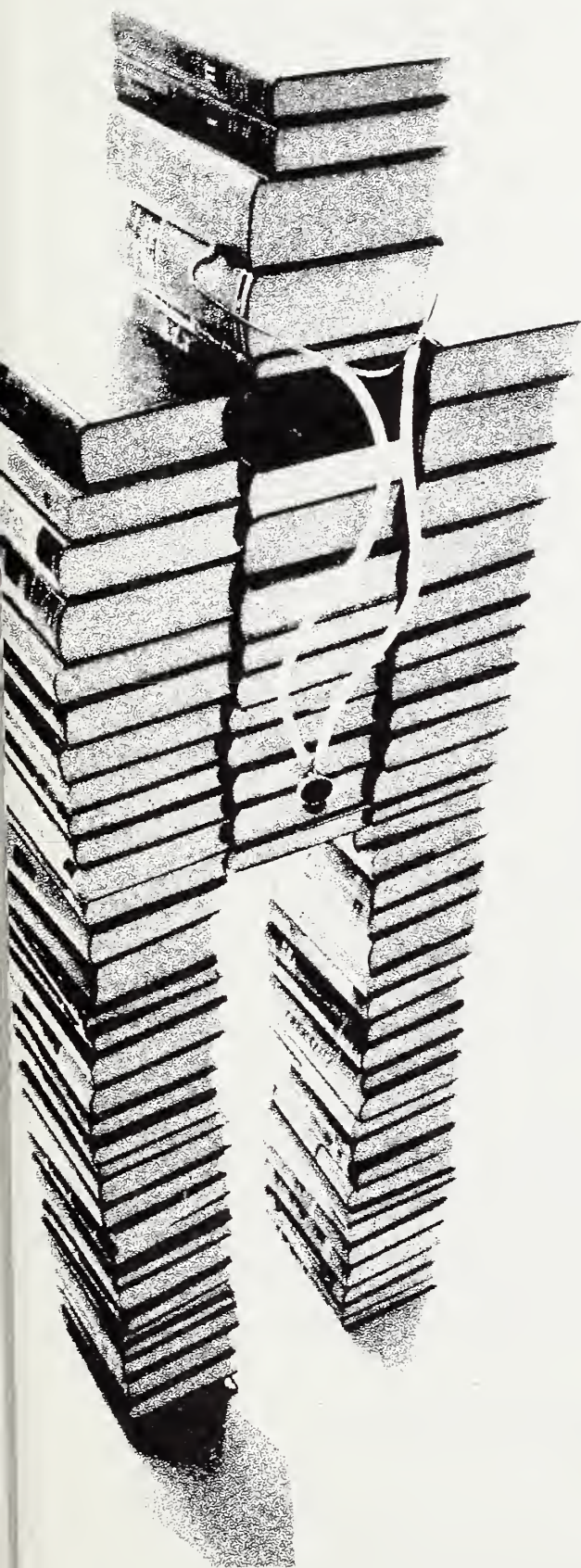
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## (methacycline HCl)

**CONTRAINDICATIONS:** Hypersensitivity to any of the tetracyclines.

**WARNINGS:** Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

**Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

**Usage in newborns, infants, and children.** (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

**PRECAUTIONS:** If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

**ADVERSE REACTIONS:** **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

**Skin:** maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

**Renal toxicity:** rise in BUN, apparently dose related (See **WARNINGS**).

**Hypersensitivity:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

**Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**USUAL DOSAGE: Adults**—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q. i. d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

**Children**—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

**Concomitant therapy:** Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

**SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73



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## Two-Way Communication Is Auxiliary Concern

"Communication is the basic instinct of all animals. Even microscopic organisms survive by feeling for the presence of food and danger — a primitive form of communication."

A special emphasis is being placed on communication this year by the national and state auxiliary in order to better serve our members and constituent auxiliaries and to reinforce our status with the local, state and national medical associations.

The objective for our communication priority this year is "Communication for Internal and Public Awareness."

"Public Awareness" will obviously include the community, other organizations and the public information media. We hope to make the community and other organizations more aware of the program services offered by the auxiliary and of active participation of doctors' wives in community affairs and health related fields. We hope to become better acquainted with personnel in the media field and encourage doctors' wives to contribute to the media fields.

Our "Internal Awareness" will include communication within the auxiliary and with physicians' associations.

Within our auxiliary we hope to encourage the members to become more familiar with national publications such as *MD's WIFE*, to provide interesting state and county newsletters, to be knowledgeable about media materials available from AMA, and to develop prompt answering of correspondence between county units and state and county units.

The lack of successful communication with medical societies and state medical associations is a concern of many auxiliaries across the

United States. And certainly, may we point out, that successful communication is a two-way street, involving input and feedback.

We will encourage each county auxiliary to arrange, by some method, to make a report to their county medical society. The state auxiliary hopes to be more successful in a two-way communication with OSMA. We hope, on a state level, it was not a step backward when we were not invited to give our usual, five-minute report, and our national president could not be introduced due to "lack of time" at the opening session of the OSMA House of Delegates last spring. In our fast-moving society, lack of time is certainly a valid reason.

This non-invitation came at the end of a year which, to paraphrase, had been A VERY GOOD YEAR. The state auxiliary was to receive national recognition for increased membership and increased AMA-ERF donation. One of our units (Atoka-Bryan-Coal) was in the running for No. 1 in the nation in per-member donation to AMA-ERF, and one of our units (Tulsa) had been nominated to receive a national safety award. Atoka-Bryan-Coal is No. 1 in the nation in per-member donation to AMA-ERF and Tulsa did receive an Award of Commendation from the National Safety Council, becoming the only organization in Oklahoma to receive national safety recognition.

We will welcome alternative methods of communication, and we hope to do a better job of two-way communication. We will have more effective input — reporting to you what we are doing, and hope for greater feedback from you — telling us what we are doing well, and what we could do better.—*Hazel Vammen, Communication Chairman, Auxiliary to the OSMA* □



**AMA members are facing a \$60 assessment for calendar year 1975 to help the financially plagued association out of debt.** The Board of Trustees of the association had originally asked for a \$90 dues increase, from \$110 per year to \$200 per year.

**The dues increase requested by the Board of Trustees was rejected overwhelmingly by the house.** Delegates voted 161 to 70 for the assessment.

**The assessment is a special problem for Oklahoma physicians,** since Oklahoma is one of only eight states that has mandatory AMA membership. Additional information for all Oklahoma physicians will be forthcoming as soon as possible.

**The House of Delegates Reference Committee that considered the long report regarding the AMA's financial situation** recommended a \$60 assessment and a \$90 dues increase to be effective January 1st, 1976. While the first half of the recommendation was overwhelmingly accepted, the second half, regarding the dues increase, was rejected.

**The Wisconsin delegation offered an amendment to strike the half of the recommendation dealing with the dues and insert the following,** "That the House (of Delegates) consider a dues structure at the meeting in June, 1975, contingent upon demonstration by the Board of Trustees of stronger economy measures and improved executive management of the association's affairs." This amendment will mean that the dues increase will be reconsidered by the House of Delegates when it convenes in June in Atlantic City for its annual meeting.

**A question was raised regarding whether or not the \$60 assessment was "mandatory" or "voluntary."** In order to make sure there was no misunderstanding, the House of Delegates voted 144 to 71 to indicate that the assessment was "mandatory." Billing for the assessment will be directly from the American

Medical Association to its members throughout the United States, including those in Oklahoma.

**A second recommendation of the House Reference Committee was rejected by the delegates,** and a substitute was introduced by the New England delegation. The substitute read as follows: "The House of Delegates instructs the Board of Trustees to rescind its actions in discontinuing councils, committees, publications and other activities of the association until the annual 1975 meeting of the House of Delegates has had an opportunity to review the whole situation again. In the meantime, (1) the situation is to be studied by a committee of the house with recommendations to be made to the House of Delegates at the annual 1975 meeting, and (2) the various activities under question are to be held in abeyance when absolutely necessary at the discretion of the Board of Trustees but kept structurally intact on paper in a holding fashion with the exception of the scientific publications which are to be continued at least until the annual 1975 meeting."

**After this recommendation was adopted by a vote of 142 to 68,** the question arose as to what financial impact it might have on the operational budget of the AMA. According to the AMA's leadership, this one action by the House of Representatives threw the budget out of balance by nearly \$2.5 million. It seemed to be the consensus of opinion among the various delegates that the \$60 assessment should take up the extra debt created by the House action. It was pointed out that whatever action they took would be only effective until the June, 1975 meeting in Atlantic City.

**It also adopted a policy stating that the AMA should continue a full unrestrained advertising program until at least the June, 1975, meeting** where the delegates could again look at the proposal that the AMA no longer accept drug advertising in its many publications.

**Due to the importance of the assessment and a possible dues increase in June,** all OSMA members will be kept fully informed through the association's *Journal* and *OSMA Comment*. □



















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